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The impact of internalized homophobia and attachment style in emerging adult gay men's attitudes toward seeking professional psychological help

Abstract

Gay men face many challenges throughout their lives. Emerging adult gay men (EAGM) are particularly vulnerable. Minority stress theory posits that these individuals often experience stigmatization, which is often internalized as self-hatred, and leads them to be at greater risk for substance abuse, depression, suicide, and sexual health problems. This is known as internalized homophobia. Secure attachment style has been found to improve one's ability to navigate and cope with emotional stress, including the ability to seek mental health services. Because one's attachment style is pivotal in how one interacts with the world, a young gay man's ability to navigate negative feelings about himself may influence and interact with his attitudes toward seeking psychological services. Therefore, the purpose of this study is to examine and clarify the role that internalized homophobia has in a young gay man's attitudes toward seeking professional psychological help when attachment style is considered.

In order to test this hypothesis, 225 EAGM ages 18 to 28 were recruited through fliers across the nation both online and in paper format. They were asked to visit a survey based website (SurveyGizmo.com) to participate in a research study about their attitudes and perceptions of themselves and of mental health services. Participants filled out four measures: a demographics questionnaire; the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994); the Internalized Homophobia Scale (IHS; Ross & Rosser, 1996); and the Attitudes Toward Seeking Professional Psychological Help – Short Form Scale (ATSPPH-SF; Fischer & Farina, 1995). Results reveal a correlation between internalized homophobia and attachment. Internalized homophobia helped predict attitudes toward seeking psychological help above age, education, and fearful attachment. However, education and fearful attachment were not significant in the regression equation. Statistical analysis and discussion is provided.

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THE IMPACT OF INTERNALIZED HOMOPHOBIA AND ATTACHMENT STYLE IN
EMERGING ADULT GAY MEN'S ATTITUDES TOWARD SEEKING PROFESSIONAL
PSYCHOLOGICAL HELP

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
PACIFIC UNIVERSITY
HILLSBORO, OREGON

BY
SIMON J.C. QUARTLY, M.S.

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF CLINICAL PSYCHOLOGY

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APPROVED BY THE COMMITTEE:

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Dedication

This study is dedicated to all of the young gay men suffering in silence. I hope this research finds you and provides you with a way out other than suicide.

This paper is also dedicated to those who seek to build a more just world for gay and minority individuals.

Finally, this paper is dedicated to my father who, in death, got a glimpse of life.

Acknowledgements

I would like to thank all those around me for their tireless support and understanding to get to this point. I would especially like to thank my mother who has supported me no matter my academic pursuits. I am very thankful for Dr. Daniel Munoz's guidance in academic and critical thinking during my Master's thesis. Dr. Sandra Jenkins, you have been the guiding force behind my academic and clinical training. I would also like to thank Dr. Keith Conant for his unrelenting support and dedication. Abby Bandurraga, you were instrumental in helping with my grammar and sentence structure. I would like to thank my dissertation chair, Dr. Robin Shallcross, for her helping me complete this dissertation in a timely way. I would also like to thank my dissertation reader, Dr. Kris Gowen, for helping me think critically about my analyses and findings.

Abstract

Gay men face many challenges throughout their lives. Emerging adult gay men (EAGM) are particularly vulnerable. Minority stress theory posits that these individuals often experience stigmatization, which is often internalized as self-hatred, and leads them to be at greater risk for substance abuse, depression, suicide, and sexual health problems. This is known as internalized homophobia. Secure attachment style has been found to improve one's ability to navigate and cope with emotional stress, including the ability to seek mental health services. Because one's attachment style is pivotal in how one interacts with the world, a young gay man's ability to navigate negative feelings about himself may influence and interact with his attitudes toward seeking psychological services. Therefore, the purpose of this study is to examine and clarify the role that internalized homophobia has in a young gay man's attitudes toward seeking professional psychological help when attachment style is considered.

In order to test this hypothesis, 225 EAGM ages 18 to 28 were recruited through fliers across the nation both online and in paper format. They were asked to visit a survey based website (SurveyGizmo.com) to participate in a research study about their attitudes and perceptions of themselves and of mental health services. Participants filled out four measures: a demographics questionnaire; the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994); the Internalized Homophobia Scale (IHS; Ross & Rosser, 1996); and the Attitudes Toward Seeking Professional Psychological Help – Short Form Scale (ATSPPH-SF; Fischer & Farina, 1995). Results reveal a correlation between internalized homophobia and attachment. Internalized homophobia helped predict attitudes toward seeking psychological help above age, education, and fearful attachment. However, education and fearful attachment were not significant in the regression equation. Statistical analysis and discussion is provided.

Keywords: Internalized Homophobia, Gay Men, Attachment, Attitudes Toward Seeking Professional Psychological Help

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Chapter I

Introduction

Statement of the Problem

Emerging adulthood. Emerging adulthood is a developmental period from approximately the ages of 18 to 30 (Arnett, 2000). This period of life is marked by a number of challenges, including identity development and self-exploration. This can be an especially difficult time for gay men. Emerging adult gay men (EAGM) face greater challenges in society (Cass, 1979). Many aspects of society denigrate and deny gay men equal rights. EAGM are vulnerable to physical and verbal harassment in school (The Gay, Lesbian and Straight Education Network; [GLSEN], 2009), disproportionately kicked out of their homes for being gay (Heineman, & Gerrard, 2007), and are rarely portrayed positively in popular culture, except in ways that depict them as effeminate, weak, or villainous (Faderman, 1997). EAGM are also denied many rights depending on their state of residence, including discrimination in areas such as housing, employment, adoption, marriage, insurance coverage, and hospital visitation rights. Gay individuals are often told from an early age that gay sexuality is abhorrent and wrong (Human Rights Campaign [HRC], 2010).

Internalized homophobia. Minority stress theory posits that minority individuals internalize these negative messages from society about themselves, which leads to psychological distress (Allport, 1979; Meyer, 1995). The internalization by lesbian, gay, and bisexual (LGB) individuals of society's negative and heterosexists views is called internalized homophobia. Many studies have found an association between negative societal views and behaviors and mental and physical health problems in EAGM individuals (O'Hanlan, Cabaj, Schatz, Lock, & Nemrow, 1997; Cole, Kemeny, Taylor, & Visscher, 1996; D'Augelli, Pilkington, & Hershberger,

2002; Ryan, Huebner, Diaz, & Sanches, 2009). Higher levels of internalized homophobia are associated with increased levels of depression and anxiety (Igartua, Gill, & Montoro, 2003); low levels of self-esteem and increased shame and sexual dysfunction (Allen & Oleson, 1999; Meyer, 1995); avoidance of relationships and substance abuse (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999); unsafe sex practices (Meyer & Dean, 1995); a potential for suicidal behavior (Reed, Prado, Matsumoto, & Amaro, 2010; D'Augelli, Hershberger, & Pilkington, 2001; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999); and more insecure types of attachment (Sherry, 2007). Furthermore, EAGM are at greater risk for illicit substance abuse, cigarette smoking, violence, and intimate partner violence (Reed, Prado, Matsumoto, & Amaro, 2010; Rhodes, McCoy, Wilkin, & Wolfson, 2009); eating disorders (Boisvert & Harrell, 2009); panic attacks, depression, and psychological distress (Cochran, Sullivan, & Mays, 2003); anxiety (Garofalo et al., 1999; Igartua, Gill, & Montoro, 2003); sexual health problems (Coleman, Rosser, & Strapko, 1992); and suicidal thoughts and behaviors (D'Augelli, Hershberger, & Pilkington, 2002).

Attachment and internalized homophobia. Although there does not appear to be a difference in frequency of attachment style between heterosexual and homosexual emerging adults (Ridge & Feeney, 1998), studies have shown that emerging adult gay individuals with secure attachment have more positive attitudes about their own homosexuality, are better able to self-disclose their minority sexual orientation (Jellison & McConnell, 2003), and are more likely to have secure attachment (Sherry, 2007). Furthermore, securely attached gay individuals are able to come out to their parents sooner and have lower levels of dysfunctional cognitions about their sexuality (Holtzen, Kenny, & Mahalik, 1995). When an EAGM has a more secure level of attachment he is better able to navigate difficult emotional states. Therapy can help change

attachment styles (Levy, Meehan, Kelly, Rynoso, Weber, Clarkin, & Kernberg, 2006) increasing EAGM's ability to navigate the world in a less self-deprecating way.

Attachment and help seeking. Attachment is pivotal in how individuals view themselves and others. Attachment patterns help individuals make sense of their experiences and expectations of others, including others' motives (Siegel, 1999; Bowlby, 1973; Wallin, 2007). Avoidant/fearful attachment has been found to be related to negative views of help seeking behavior in emerging adults (Vogel & Wei, 2005; Lopez, Melendez, Sauer, Berger, & Wyssmann, 1998; Feeney & Ryan, 1994). Specifically, those who experience avoidant/fearful attachment tend to view psychological help more negatively and to view themselves as not having psychological difficulties, while secure attachment style has been found to improve one's ability to navigate and cope with emotional stress, including the ability to seek mental health services (Vogel & Wei, 2005; Feeney & Ryan, 1994).

EAGM and attitudes toward seeking professional psychological help. Given the internal and external difficulties EAGM face therapy can be very important in helping them traverse difficult life stressors, thus improving their mental and physical health. However, young adults do not seek therapy very often (Vogel, Gentile, & Kaplan, 2008; Vogel, Wade, & Hackler, 2008). This is particularly true for young men and young gay men (Davies, Byron, McCrae, Frank, Dochnahl, Pickering, Harrison, Zakrzewski, & Wilson, 2000). Although young LGBT individuals seek therapy more often than their heterosexual peers (Cochran, Sullivan, & Mays, 2003; Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Jones, & Gabriel, 1999), there are many barriers to EAGM seeking help. Such barriers include rigid gender adherence (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Simonsen, Blazina, & Watkins, 2000; & Simonsen 1998); concerns about feeling safe, accepted, understood; concerns about the

competence of the therapist (Davies et al., 2000); and the fear of potential sexual orientation micro-aggressions perpetrated by the therapist (Shelton & Delgado-Romero, 2011). Yet, studies have failed to analyze if internalized homophobia has an impact on an individual's attitudes toward help seeking.

Summary. Internalized homophobia is related, to some degree, to the development of psychological challenges. Additionally, there appears to be a relationship between internalized homophobia and attachment style among gay men (Sherry, 2007). This study seeks to clarify to what degree this is true for EAGM. Furthermore, internalized homophobia also seems to be related to negative views of help seeking behaviors. Yet, it has not been formally explored in the research. Avoidant attachment is correlated with negative views of help seeking behaviors among emerging adults. This study further seeks to clarify these hypotheses in EAGM and to understand the degree to which help seeking behaviors among EAGM are influenced by their attachment style and internalized homophobia.

Purpose of the Study

The purpose of this study is to provide therapists and researchers with information regarding EAGM and their attitudes toward seeking professional psychological help. While fearful/avoidant attachment has been found to mitigate positive attitudes among young adults toward seeking psychological services, minimal research has been done on the effects of internalized homophobia and attachment on attitudes toward seeking psychological help. This research seeks to understand the effects attachment and internalized homophobia have on attitudes toward seeking psychological help among EAGM in order to address the gaps in the research and inform practitioners who work with this population in the areas of outreach, treatment planning, and interventions. Specifically, the purpose of this study is to: (1) assess

internalized homophobia and attachment in EAGM; (2) evaluate the impact internalized homophobia and attachment have on EAGM's attitudes toward seeking professional psychological help; and (3) investigate the degree to which internalized homophobia accounts for attitudes toward seeking professional psychological help when other factors, such as age, level of education, and attachment style are considered.

Research Questions and Hypotheses

The following research questions and corresponding hypotheses are addressed in this study:

Question 1: Is there a relationship between EAGM's attachment style and internalized homophobia?

Hypothesis 1: EAGM with higher levels of internalized homophobia will have higher levels of fearful and/or preoccupied attachment styles and lower levels of secure attachment. Dismissing attachment will be examined. Each scale of internalized homophobia will be examined. The subscales are: public identification as gay; social comfort with gay men; perception of stigma associated with being gay; and moral and religious acceptability of being gay.

Question 2: Is there a relationship between attitudes toward seeking professional psychological help and internalized homophobia among EAGM?

Hypothesis 2: EAGM with higher levels of internalized homophobia will have more negative attitudes toward seeking professional psychological services than EAGM with lower levels of internalized homophobia. Each scale of internalized homophobia will be examined.

Question 3: Is there a relationship between EAGM's attachment style and their attitudes toward seeking professional psychological help?

Hypothesis 3: EAGM who have higher levels of avoidant/fearful attachment will also have more negative attitudes toward seeking professional psychological services. Dismissing and secure attachment will be examined in terms of their impact on attitudes toward seeking professional psychological help.

Question 4: To what degree does internalized homophobia help predict attitudes toward seeking professional psychological help above and beyond fearful and/or preoccupied attachment style in EAGM?

Hypothesis 4: Internalized homophobia will help predict attitudes toward seeking psychological help above and beyond fearful attachment and/or preoccupied attachment among EAGM. Each scale of internalized homophobia will be examined.

Summary

The focus of this study is to examine the association among attachment, internalized homophobia, and attitudes toward seeking professional psychological help in EAGM. This study begins with a literature review synthesizing the theoretical and empirical literature on heterosexism and internalized homophobia; attachment; emerging adulthood in gay men; barriers and psychological stresses gay men experience; attitudes toward help seeking among gay men; and attachment styles in relation to attitudes toward seeking psychological help in emerging adults. The methods used to carry out this research are discussed in Chapter 3, followed by a discussion of results in Chapter 4. Finally, Chapter 5 provides a discussion synthesizing the findings and discussing the implications of this research for practitioners and researchers in psychology as well as the potential for future research to build on the current study.

Chapter II

Literature Review

This literature review and study is based on research from a western perspective and participants were recruited from the United States. Homosexuality is viewed differently in other cultures and may be different from this study. However, it is beyond the scope and purpose of this literature review and study to examine non-western understandings of homosexuality and internalized homophobia. This creates an inherent limitation in the generalizability of this study to other cultures. This also creates a basis for further research in other cultures regarding homosexuality and help seeking.

Heterosexism

According to Herek (1990), heterosexism is as an “ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community” (as cited in Smith, Oades, & McCarthy, 2012, p. 5). It is a system that assumes individuals are inherently heterosexual (Meyer, 1995; Meyer & Dean, 1998). From an early age children are taught sexual norms, such as boys are to be masculine, and to be masculine a man should not show affection for another man (Hudepohl, Adam, Parrott, Dominic, Zeichner, & Amos, 2010; O’Neil, 1981). Because heterosexism is persistent and all-encompassing, many homosexuals from an early age report vague feelings of being weird, that somehow they do not belong, and that they are different from their peers and society (Gonsiorek, 1995; Hunter & Schaecher, 1987). A significant, but unknown, number of gay men begin to develop negative feelings towards themselves (Gonsiorek, 1995). Their sexuality appears to be ego-dystonic from their ideal self (Cass, 1983, 1979; McWilliams, 2011). Balint (1935) developed the idea of “primary love,” which is the desire to “be loved always, everywhere, in every way, my whole

body, my whole being” (p. 50). Balint viewed neurosis as the result of splitting off the parts of one’s self that are punished or denied by others. EAGM are often denied this love. They experience this as a severe narcissistic injury, also known as internalized homophobia (Gonsiorek, 1995).

Overview of Internalized Homophobia

Allport’s (1979) theory of stigma and prejudice conceptualized reactions to stigma as “traits due to victimization” (p. 142). These traits can be expressed in either an extroverted and/or introverted way. An extroverted expression is similar to reaction formation whereby an individual handles unacceptable emotions and impulses, particularly stigmatizing characteristics, by acting out the opposite. An introverted expression of stigmatization is characterized by the devaluing of oneself and identifying with the aggressor (Allport, 1979). Internalized homophobia parallels Allport’s theory of both extroverted and introverted expressions of stigmatization. An introverted expression happens when a stigmatized lesbian, gay, or bisexual (LGB) individual internalizes the negative beliefs of the heterosexual majority. An extroverted expression of stigmatization happens when an LGB individual acts against homosexuality. Behaviorally, an extroverted expression may involve individuals taking on hyper-masculine characteristics, distancing themselves to an extreme from LGB individuals, while denigrating and vilifying LGB individuals (Adams, Wright, & Lohr, 1996). Other external expressions include thoughts of suicide and suicide attempts, sexually risky behaviors, drug use, and violence (Rhodes, McCoy, Wilkin, & Wolfson, 2009; Igartua, Gill, & Montoro, 2003; D’Augelli, Hersherberger, & Pilkington, 2001; Meyer & Dean, 1995).

More recent theories of internalized homophobia have extended Allport’s original conceptualization. Meyer (1995) defines internalized homophobia as a homosexual’s

internalization of society's homophobic attitudes. Dean and Meyer (1998) state that internalized homophobia is "the gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard" (p. 161). The authors note an incongruence between an individual's needs and the current social structures, positing that because of this many gay individuals internalize societal hatred. They start to devalue themselves because of their sexuality.

Hudson and Ricketts' (1980) proposed concept is slightly different than Dean and Meyer's (1995) conceptualization in that the authors find that homophobia/heterosexism and internalized homophobia are not distinct. They contend that all members of a homo-negative (i.e., homophobic/heterosexist) society incorporate and convey homo-negative attitudes. They do not view internalized homophobia as something to be corrected. They contend that claiming a homosexual has internalized homophobia is analogous to homosexual denigration and blame. They view the origins and cause to be societal homophobia and that internalized homophobia places the blame on homosexuals rather than on society. Thus, Hudson and Ricketts (1980) do not define internalized homophobia on an individual basis, but rather on a societal basis. They use the term "homo-negative," not "internalized homophobia," in order to emphasize the point that regardless of sexual orientation everyone in a homophobic society has internalized homophobia, which is similar to a contemporary psychoanalytic conceptualization of sexuality. Psychoanalytic theory has similarly been criticized for emphasizing the pathology of homosexuality.

Many psychoanalytic theorists built upon Allport's conceptualization of stigmatization to define internalized homophobia. Their departure comes in the form of unconscious processes. They claim the behaviors associated with stigmatization are largely unconscious. There is an

unconscious internalized hatred of oneself resulting from anxieties about being or becoming gay, resulting in acting out against those anxieties (De Kuyper, 1993; McWilliams, 2011). Chodorow (1999) claims that any internal challenge to the separateness of “hetero-erotic and homo-erotic fantasies and attachments threatens real disintegration” (p. 15). This means that any internal or external threat to a man, gay or straight, such as femininity or submissiveness, has to be split off and projected outward due to the fear that these threats will meld with the self and that the individual will have some understanding that they are homosexual (McWilliams, 2011).

Therefore, individuals in a homo-negative society feel the need to destroy any homoerotic feelings both internally and externally. Research studies have supported the utility of this theory and Allport’s extroverted expression of stigma. Adams, Wright, and Lohr (1996) studied homophobia in relation to homosexual arousal. By measuring penile circumference (plethysmograph) of both homophobic and non-homophobic heterosexual men whose homophobia was measured by the Index of Homophobia, they found that homophobic men showed a significant increase in erection when shown homoerotic stimuli compared to those who scored low on the Index of Homophobia. Weinstein, Ryan, DeHaan, Przybylski, Legate, and Ryan (2012) found similar results.

It is clear from the theoretical findings that internalized homophobia can be defined as the internalization and projection of negative attitudes, thoughts, and feelings about homosexuality in all members of society, not just gay individuals. However, for the purpose of this study I will be utilizing Dean and Meyer’s (1998) theory of internalized homophobia rather than the all-encompassing conceptualization of homo-negativity. Given that this study is concerned with emerging adults who self-identify as gay or questioning, internalized homophobia is a more practical and useful framework.

Overview of Attachment

The origin of attachment theory is largely attributed to Bowlby (1940; 1951; 1988). Although Bowlby had talked previously about the importance of the parent child bond (Bowlby, 1940), it wasn't until 1951 with the publication of his World Health Organization Report (1951) that he cemented his theoretical understanding of attachment. Bowlby (1988) believed in a biological and evolutionary need for children to attach to their primary caregiver. This was the basis for his conceptualization and observation of child/parent bonds and their disruption. Bowlby studied many children who were displaced or orphaned. He observed their behavior in relation to a lack of parental attachment figures. Bowlby posited that if the parent child attachment was not attended to in terms of the mother/infant bond a child would develop maladaptive internal representations of self and other (Bowlby, 1973). Specifically, Bowlby postulated that early infantile proximity and protection correlates with later understandings of how an individual interacts with the world, which he called an internal working model. This internal model prompts the attachment system in the child. This is a system in which the infant seeks proximity to the caregiver, and proximity provides protection when they experience anxiety or fear. Bowlby hypothesized that an attachment system develops out of a biological and evolutionary need to maintain proximity between infants and their caretakers under conditions of danger or threat (Bowlby, 1973; Bartholomew & Horowitz, 1991). In order to maintain mental health, Bowlby (1951) stated, "The infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (p. 13).

Bowlby postulated a cognitive working model (CWM) of positive and negative images of self and other. Specifically, Bowlby's CWM is comprised of: "(a) whether or not the attachment

figure is judged to be the sort of person who in general responds to calls for support and protection; [and] (b) whether or not the self is judged to be the sort of person towards whom anyone, and the attachment figure in particular, is likely to respond in a helpful way” (Bowlby, 1973; p. 204; as cited in Bartholomew & Horowitz, 1991). The first part describes the child’s view of others as positive or negative, while the latter is concerned with how the child views themselves in relation to others. Children who experience their primary caregiver as supportive and protective develop a working attachment model of self and other as secure, reliable, trustworthy, dependable, and, most importantly, as deserving of love and care both internally and from outside. Children who experience their primary caregiver as unavailable and nonresponsive to their needs develop an attachment model of self and other as insecure, unpredictable, and unreliable. These individuals and children do not feel they deserve either internal or external love (Bowlby, 1988; Bretherton & Munholland, 1999).

Bowlby’s conceptualization was revolutionary at the time. His ideas often evoked strong criticism from the British psychoanalytic community, particularly in reaction to his response to the World Health Organization Report (1951) detailing the negative effects of parent child separation, as it was understood at the time, that a child’s model of the self was represented in fantasy rather than interactional effects of mother and child (Bretherton, 1992). Ainsworth set out to operationalize Bowlby’s concept of interaction between the parent and child as the driving force in the development of an attachment model and not merely as a characteristic of the child. In her Strange Situation experiment, Ainsworth tested infant’s attachment style by first having the child and parent go into a room alone (Ainsworth, Blehar, Waters, & Wall, 1978). Next, a stranger would enter the room. The mother then leaves the room and after a while the mother would return. Ainsworth looked at four parts of the situation. First, she looked at the amount of

exploration a child engaged in across the experiment. Next, she looked at the child's reaction to the departure of the parent, followed by examining the child's reaction to the stranger. Finally, she noted the child's behavior once the parent returned. From these observations she was able to note three types of attachment styles: secure, ambivalent insecure attachment, and avoidant insecure attachment (Ainsworth, Blehar, Waters, & Wall, 1978).

The securely attached infant freely explored and even played with the stranger while the mother was in the room. Although the infant became visibly distressed when the mother left and did not play with the stranger, the infant was easily soothed upon her return. The infant was able to explore and play having the knowledge that a secure base will return in times of need. Some hypothesize the child is capable of having a mental representation of the mother to sooth themselves, similar to conceptualizations of child distress tolerance (for a review on mentalization see Fonagy, Gergely, Jurist, & Target, 2005). An ambivalent child will often seek the mother's attention. However, when contact is made the child displays a desire to move away from the mother. When the mother puts the child down the child becomes unduly upset. The child is anxious of exploration, play, and the stranger, with or without the mother in the room. A similar situation happens when the mother leaves the room. The child becomes very upset. Yet, upon her return the child will often hit or punch the mother and fail to be soothed when picked up. Praise and appropriate attention of the child is inconsistent. At times the caregiver will meet the child's needs, while at other times the caregiver will be disengaged. Thus, the child has internalized this inconsistency in self and others.

Avoidant children will not seek closeness nor show a desire for contact with the mother. The child will show no emotion upon the caregiver's departure or return. The child will avoid eye contact and show little emotion when picked up by the mother. Similar behaviors are

exhibited in the child's interaction with the stranger. Parents in this group exhibit behaviors of neglect, indifference, and rejection of the child and their needs. This leads to internalization in the child that they cannot get their needs met outside of themselves, and that they are unworthy of love. Main, a colleague of Ainsworth, developed a fourth attachment style: disorganized attachment (Main & Solomon, 1990). Children in this category will often display contradictory and unpredictable emotions. They would often desire attachment, but then become avoidant, often freezing or falling on the floor only to then show extreme distress and an exaggerated movement away from the mother. Most caregivers of these children have extensive unresolved trauma histories (Main & Hesse, 1993). Their children internalize the disorganized fear of their parent. Bartholomew and Horowitz (1991) developed a model of attachment based on Bowlby's (1973) CWM of positive and negative images of self and other: a two by two model of positive and negative views of self and other. Table 1 shows Bowlby (1973) and Bartholomew and Horowitz's model of attachment.

Table 1
Bartholomew & Horowitz's (1991) 2X2 Model of Self and Other

		Model of Self (Anxiety)	
		Positive (Low)	Negative (High)
Model of Other (Avoidance)	Positive (Low)	Secure High self-worth, believes others will be responsive, comfortable with autonomy and in forming close relationships with others	Preoccupied A sense of self-worth that is dependent on gaining the approval and acceptance of others
	Negative (High)	Dismissing Over positive self-view, denies feelings of subjective distress and dismisses the importance of close relationships	Fearful/Avoidant Negative self-view, lack of trust in others, subsequent apprehension about close relationships and high levels of distress

Neurological Developmental Attachment

Recent developments in neuropsychology have in part validated Bowlby's (1988) biological theory of attachment, namely the idea that early infantile proximity and protection correlates with later understandings of how an individual interacts with the world. By the second year of life an infant develops an internal representation of the attachment relationship (Minagawa-Kawai, Matsuoka, Dan, Naoi, Nakamura, & Kojima, 2009). Once formed, this representation is relatively stable and guides the infant's behavior in new situations (Bretherton & Munholland, 1999; Belsky, Campbell, Cohn, & Moore, 1996; Waters, 1978; Owen, Easterbrooks, Chase-Lansdale, & Goldberg, 1984; Main, Kaplan, & Cassidy, 1985). However, the attachment system is subject to modification based on subsequent experience, such as therapy in adulthood (Levy et al., 2006). Recent research has found that attachment is not merely a psychological phenomenon, but also represents neurological hardwiring. It is now understood that our environment helps in not only protein development, but also gene expression (Siegel, 1999). The relationship a child has with their primary caregiver directly influences brain development. Shore stated, "The baby's brain is not only affected by these interactions; its growth literally requires brain (to) brain interactions and occurs in the context of a positive relationship between mother and infant" (as cited in Wallin, 2007, p. 69). Attachment leads to specific organizational changes in an infant's brain. Based on studies of the maturation of the limbic, pituitary, and right orbital prefrontal cortex regions of the brain, as well as mirror neurons, it is understood that the caregiver-infant relationship directly influences development of affect, affect regulation, and cognitive process in infant development, which are central components in the working model of self and other (Minagawa-Kawai et al., 2009; Siegel, 1999; Sonkin, 2009; Spangler, & Grossmann, 1993). Schore (2011) posits that these areas of the brain

are the first to develop, thus prompting the attachment system early in life. When massive synaptic pruning happens those areas that are not stimulated or supported die off. It is recognized as fact that cells that fire together wire together and cells that do not die together. Thus, Schore argues the first few years of an infant's life are the most important in developing an attachment model. When the infant is not emotionally stimulated and co-regulated with the caregiver those areas of cell development are pruned, thus mitigating secure attachment.

Adult Attachment Behaviors

Adults who are securely attached can transition from negative to positive emotions as called for by the situation (Siegel, 1999). They show resilience under stress. They are capable of self-soothing and seeking comfort. When stressed, securely attached individuals are able to healthily navigate negative emotional states. Consistent with Bowlby (1973), these individuals have a positive image of self and others. They do not expect malice from others, nor do they feel unworthy of love. On the other hand, ambivalent children develop into preoccupied adults. Preoccupied individuals are able to join with others, but in a conflicting and contradictory way. They are often preoccupied with past relationship experiences and are often angry, passive, and fearful. They cannot recall events in a coherent manner and often express anger with regard to current relationships (Siegel, 1999). Dismissive individuals are often self-involved. They deny a need for relationships with others. They have a difficult time trusting others (Wallin, 2007). They are compulsively self-reliant (Bowlby, 1982). According to Wallin (2007), "Their over self-reliance and defensive overestimation of their own value require that they remain remote from whatever feelings, thoughts, or desires might provoke them to seek support, connection, or care from others" (p. 211). These individuals are highly defensive. Their recollections of past events are often unsupported or contradictory (Siegel, 1999).

Avoidant children often develop as avoidant/fearful adults. There are contradictions in their stories about relatedness to others. They often overgeneralize. They also tend to not value attachment or relationships. They present as non-emotional, and often project a false self. Similar to their childhood, disorganized/unresolved adults often lose touch with reality. They often present loose, confusing, and tangential understandings of relationships. Disorganized individuals are often easily upset, confused, and chaotic in their interactions with others. They are often disconnected from the reality and context of the situation. They do not have the psychological resources to navigate emotional states, which continue beyond the stressful situation. These individuals are often victims of abuse or neglect and present with borderline personality functioning (Siegel, 1999, p. 74; Bakermans-Kranenburg, & Van-IJzendoorn, 1993; Main & Hesse, 1993).

Attachment and Internalized Homophobia in Gay Men

The frequency of distinct attachment styles does not appear to be different between heterosexual and homosexual emerging adults (See Table 2; Ridge & Feeney, 1998). However, multiple studies have shown that gay individuals' attachment style is correlated with how they view themselves. Jellison and McConnell (2003) demonstrated that gay men with a more secure attachment style endorsed more positive attitudes about their own homosexuality. Additionally, they found that more positive attitudes toward one's homosexuality mediated the relationship between secure attachment and greater levels of self-disclosure and greater levels of self-esteem. In terms of EAGM ($M = 28.64$ years; $SD = 6.5$), Holtzen, Kenny, and Mahalik (1995) found that gay individuals with secure attachment came out to their parents sooner and reported lower levels of dysfunctional cognitions. Sherry (2007) studied the connection between internalized homophobia and attachment style. Sherry found negative correlations between secure attachment

and internalized homophobia, shame, and guilt, while fearful and preoccupied attachment was positively correlated with these constructs. Although gay and heterosexual individual's attachment styles are not different, it appears that internalized homophobia is correlated with insecure forms of attachment.

Table 2
Frequencies of Attachment Styles in young Homosexual and Heterosexual Individuals

	Homosexual (n=177) Mean age (25) SD (6)	Heterosexual (n=150) Mean age (22) SD (8)
Secure	38%	45%
Fearful	23%	23%
Pre-occupied	16%	14%
Dismissing	23%	18%

Psychological Distress, Attachment Style, and Help Seeking

Psychological distress and help seeking behavior is correlated with various insecure attachment patterns, such as anxious attachment (Vogel & Wei, 2005; Lopez et al., 1998). However, studies are mixed concerning the level of psychological distress in avoidant/fearful individuals. Conceptually, any advances by an avoidant individual in childhood to get close to their caregiver were met with consistent rejection. The parent exhibits behaviors of neglect, emotional distance, and rejection of the child. This leads to an internalization in the child that they cannot get their needs met outside themselves and, in fact, that it is dangerous to ask for help (Mikulincer, Shaver, & Pereg, 2003; Siegel, 1999). This may cause an individual to deny, mitigate, or not recognize psychological distress (Collins, 1996). Lopez et al. (1998) found that individuals with high levels of avoidant and low levels of anxious attachment did not report greater psychological symptoms than those who were securely attached. Furthermore, in a study by Lopez, Mauricio, Gormley, Simko, and Berger (2001) avoidant individuals reported neither

depressive nor anxious symptomatology. However, when using a battery of distress measures, compared to single measures, Wei, Heppner, and Mallinckrodt (2003) found a correlation between avoidant attachment and psychological distress. In addition, avoidant individuals scored high in anxiety on projective assessments, although they still denied distress or anxiety (Fuendeling, 1998; Mikulincer, Florian, & Tolmacz, 1990). Further analysis reveals more unconscious and maladaptive ways of coping with psychological distress among individuals with avoidant-attachment. Lopez, Mitchell, and Gormley (2002) found that “attachment anxiety and avoidance scores were prominently related to less coherent and less authentic self-structures” (p. 464). Furthermore, Wei, Vogel, Ku, and Zakalik (2005) found that these individuals avoid psychological distress through emotionally cutting off and distancing themselves from negative feelings, which the authors found only serves to increase an avoidant individual’s psychological distress, including depression and loneliness. These individuals tend to avoid external support in coping with distress and to view others as incapable and unwilling to help (Mikulincer et al., 2003). Consequently, these individuals are less likely to seek or view professional psychological help as viable form of assistance.

Although little to no research has been done on how EAGM and their various adult attachment styles affect their attitudes toward seeking professional psychological help, research has been conducted on how college student’s attachment relates to their attitudes toward help seeking. With a primarily white (78%) college sample (age: $M= 20.95$; $SD= 4.25$), Lopez et al. (1998) found that students with more secure attachment reported less psychological distress than those students with insecure attachment. Furthermore, the authors found that for those with psychological problems, avoidant/fearful and preoccupied individuals were less willing to seek professional psychological help than those with secure or dismissive attachment. Similar to

Lopez et al.'s (1998) results, Feeney and Ryan (1994) found that individuals with avoidant/fearful attachment were less willing to seek professional psychological help. Similarly, avoidant/fearful attachment was associated with ineffective ways of seeking support (Collins & Feeney, 2000). Even individuals with serious psychological problems who had avoidant/fearful attachment were least likely to seek psychological services than any other attachment style (Dozier, 1990). Vogel and Wei (2005) studied 355 college students at a large Midwestern university. They found that individuals with attachment avoidance were less likely to seek professional psychological help while individuals with anxious attachment styles were more likely to seek help. The studies above seem to suggest that avoidant/fearful attachment may not facilitate participation in psychological services when psychologically stressed (particularly among college students/emerging adults).

Emerging Adulthood

In order to build a theoretical framework for what Arnett (2000) calls emerging adulthood, he relied on various theorists. Arnett (2000) built upon Erikson's theory of prolonged adolescence, which Erikson states, "is typical of industrialized societies and on the psychosocial moratorium granted to young people in such societies during which the young adult through free role experimentation may find a niche in some section of his society" (as cited in Arnett 2000, p. 470). Arnett also utilized Levinson and Keniston's idea that youth utilize the time between adolescence and young adulthood as a period of continued role experimentation. Levinson argued that the ages of 17-33 represent "the novice phase of development and argued that the overriding task of this phase is to move into the adult world and build a stable life structure" (as cited in Arnett 2000, p. 470).

Arnett (2000) proposed that emerging adulthood is a distinct developmental period distinguished from adolescence and adulthood with a focus on ages 18 to approximately 28. Arnett saw the need for a distinct developmental phase during an individual's late teens and early 20s by analyzing census data, higher education attendance, and the literature regarding behaviors and activities of individuals in this age group. He found these individuals are staying in school longer, having children later, getting married later, and changing their residence more often than people of the same age 50-60 years ago. Arnett hypothesized that this allows young individuals to explore various possible life directions. Similar to Levinson's (1978) idea of this period being the time where an individual explores various life possibilities, including where they see themselves in the future, Arnett claims that this time is part of an individual's identity exploration. Arnett (2000) indicates many reasons for this new developmental stage including drastic economic change and changes in cultural understandings of sex and cohabitation. Given these changes, emerging adults tend to not see themselves as either adolescents or as adults. They see themselves as "in-between," and only by their late 20s and early 30s do they start identifying more as adults (Arnett, 2004).

Emerging Adult Gay Male Development

Many emerging adults face daunting challenges during this time. Consistent with research on heterosexual emerging adults, bisexual men also use their late teens and early twenties for identity exploration (Brewster, & Moradia, 2010). EAGM in this stage must also contend with both the internal conflict of not living up to society's "ideal heterosexual image" (Cass, 1983, p. 145) while also exploring their identity.

Most gay men go through added developmental stages, marked by confusion, despair, low self-acceptance, and low self-esteem (Ross & Rosser, 1996). LGB individuals contend with

added developmental stages. Many theorists have termed these stages “the coming out process.” These stages are not fixed. An individual can go back and forth between stages given environmental, social, and psychological circumstances. Cass (1979), Coleman (1982), Dank (1971), Grace (1979), Hencken and O’Dowd (1977), Lee (1977), Plummer (1975), and Troiden (1979) have all proposed various stages LGB individuals go through in adolescence and young adulthood (cited in D’augelli, & Patterson, 1995). Coming out is seen as a positive step in self-acceptance, and represents an important aspect in determining internalized homophobia. Being in the closet is one of the best predictors of internalized homophobia (Brown & Trevethan, 2010; Nungesser, 1983). The various theoretical models of coming out differ in terms of precise stages and the number of stages in the coming out process (see D’augelli, & Patterson, 1995 for a full review).

There are a lot of similarities among the various identity development models. An often-cited model is Cass (1979). Her identity development model represents six stages: Stage one is marked by identity confusion. This is when individuals’ experience their first realization that their behavior may be considered gay. Individuals in this stage are largely uncomfortable with the idea of being gay. They may also try to repress, deny, or rationalize their same sex attraction. However, when individuals can no longer deny their feelings, they seek to reduce their confusion, leading them to the next stage. Stage two is marked by identity comparison. In this stage individuals consider the possibility that their behaviors and attractions represent what they understand as being gay. During this stage individuals must contend with feelings of alienation. Cass describes four ways of navigating this process, an individual can: (1) “devalue the importance of others and present a public image of heterosexuality...allowing them to pass as heterosexual;” (2) “reduce the importance of a gay or lesbian self-image” allowing them to reject

a gay identity; (3) “reduce the fear of others’ negative reactions” by concealing or hiding their same-sex attraction; (4) “inhibit same-sex behaviors; devalue homosexuality, and esteem heterosexuality” (as cited in Ritter, & Terndrup, 2002, 93-94). Individuals move on from this stage when they no longer utilize the four coping strategies or the strategies become too discordant with how they feel about themselves. Stage three is marked by identity tolerance. In this stage individuals admit to the possibility of being gay or having a gay identity. They tolerate a gay image, but they do not fully accept one. This alleviates some of the anxiety individuals have around same-sex attractions, including an acknowledgement of their social, emotional, and sexual needs. However, individuals in this stage begin to feel isolated because of how they see themselves (as homosexual) and how others view them (as heterosexual). As the isolation becomes more severe, these individuals seek out other sexual minority individuals. This may be done covertly with the aim of not alerting others to their minority status. When the interactions are positive individuals feel further connected to the gay and lesbian community, often leading them to stage four. Stage four is identity acceptance. This stage is marked by an acceptance of a gay identity. Individuals in this stage seek out more connections with other sexual minorities. When positive, these relationships lead sexual minorities to feel validated and normal. Individuals begin to explore different subgroups during this stage, trying to find what fits for them. Individuals also experiment with disclosure at this time. Stage five is called identity pride. Individuals in this stage become very proud of their minority status. They are acutely aware of the differences in how they view themselves and their minority status with pride and how others devalue their sexual orientation. They tend to only associate with other sexual minorities, often devaluing heterosexuality. There are deep feelings of hostility and anger toward heterosexuals. When minority individuals can no longer accept the cognitive dissonance that all heterosexuals

are bad, they tend to move on to stage six. In stage six there is an identity synthesis. Stage five's "us against them" mentality is gone. Individuals in this stage feel less angry and hostile toward heterosexual individuals. While heterosexuals become more integrated into the individual's life, unsupportive heterosexuals are still devalued. Sexual minorities are able to see heterosexuals as both good and bad. These individuals feel greater security in themselves and their sexuality.

While many LGB individuals can navigate this process with improved psychological health, others get stuck or fixated in various stages due to a myriad of factors, including social, environmental, psychological, and feelings of safety. Like most psychologically challenging tasks, such as coping with a traumatic event, the healthy navigation of the coming out process, largely depends on the LGB individual's level of functioning prior to the process (D'Augelli, & Patterson, 1995). Yet, the external challenges to developing an integrated sexual-self are daunting, particularly at a young age (D'Augelli, & Patterson, 1995).

Internalized Homophobia and its Effects on Gay Men

Extensive research has been conducted on how internalized homophobia affects gay men. Many studies have found an association between negative societal views and behaviors and mental and physical health problems in EAGM individuals (O'Hanlan, Cabaj, Schatz, Lock, & Nemrow, 1997; Cole, Kemeny, Taylor, & Visscher, 1996; D'Augelli, Pilkington, & Hershberger, 2002; Ryan, Huebner, Diaz, & Sanches, 2009). Increases in internalized homophobia are correlated with high levels of depression and anxiety (Igartua, Gill, & Montoro, 2003); low levels of self-esteem and increased shame and sexual dysfunction (Allen & Oleson, 1999; Meyer, 1995); avoidance of relationships; substance abuse (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999); unsafe sex practices (Meyer & Dean, 1995); a potential for suicidal behavior

(D'Augelli, Hersherberger, & Pilkington, 2001; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999); and more insecure types of attachment (Sherry, 2007).

Igartua, Gill, and Montoro (2003) found that internalized homophobia is associated with depression and anxiety in gay men. Although they found that suicide is correlated with internalized homophobia, they were not able to predict suicide independently from depression. Yet, Meyer (1995) found a correlation between internalized homophobia and suicide.

The research correlating non-condom usage and internalized homophobia is weak and inconsistent. Shidlo (1994) found no correlation between non-condom usage and internalized homophobia. However, Meyer and Dean (1995) found a correlation between internalized homophobia and high-risk sexual behaviors. While these findings are with regard to risky sexual behavior sampling difficulties with a gay male population should be considered. An unknown number of closeted (non-out) gay men are not represented in these studies (Harry, 1990). Thus, making definitive conclusions about internalized homophobia and risky sexual behavior is difficult.

A study by Meyer (1995) found that demoralization, which encompasses helplessness, hopelessness, poor self-esteem, and confused thinking, was correlated with internalized homophobia. Guilt, suicide, AIDS related traumatic stress response, and sexual problems (a measure of problems related to inhibited sexual desire, excitement, or orgasm), were also correlated with internalized homophobia. Behaviorally, internalized homophobia is related to sexual dysfunction (Meyer & Dean, 1998), avoidance of relationships, intimacy, and substance abuse (Coleman, Rosser, & Strapko, 1992). Internalized homophobia has also been correlated with internal models of shame and low self-esteem (Allen & Oleson, 1999).

It is clear that high levels of depression, high levels of anxiety, low levels of self-esteem, sexual dysfunction, avoidance of relationships, substance abuse, and suicidal tendencies are associated with internalized homophobia.

Psychological Health and Attitudes Toward Help Seeking Among Gay Men and Emerging Adults

The psychiatric community has historically pathologized gay individuals. Until 1973 the Diagnostic and Statistical Manual of Mental Disorders (DSM) classified homosexuality as a mental disorder. The committee replaced the disorder in 1980 with ego-dystonic homosexuality, and in 1987 the DSM removed this category altogether with the publication of the DSM-III-R (Fox, 1988). However, it was not until 2009 the American Psychological Association (APA, 2009) came out against changing sexual orientation stating, that “mental health professionals...(must) avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others’ sexual orientation” (p. 31).

Many studies have documented that men in general, regardless of age, race, nationality, or ethnic identity, are less likely to seek psychological help than women (Husaini, Moore, & Cain, 1994; McKay, Rutherford, Cacciola, & Kabasakalian-McKay, 1996; Padesky & Hammen, 1981). EAGM are at greater risk for illicit substance abuse, cigarette smoking, violence, and intimate partner violence (Reed, Prado, Matsumoto, & Amaro, 2010; Rhodes, McCoy, Wilkin, & Wolfson, 2009); eating disorders (Boisvert & Harrell, 2009); panic attacks, depression, and psychological distress (Cochran, Sullivan, & Mays, 2003); anxiety (Garofalo et al., 1999; Igartua, Gill, & Montoro, 2003); sexual health problems (Coleman, Rosser, & Strapko, 1992); and suicidal thoughts and behaviors (D’Augelli, Hershberger, & Pilkington, 2001). Sexual

minorities utilize mental health services more often when compared to their heterosexual counterparts (Cochran, Sullivan, & Mays, 2003; Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Jones, & Gabriel, 1999). Specifically, Ciro et al. (2005) found that LGBTQ (Questioning) youth express a greater desire to talk to a therapist about their personal lives, substance use, health difficulties, and friends than their heterosexual peers. Gay male victims of sexual assault were more likely to seek psychological services than other types of criminal victimization (Rose & Mechanic, 2002). Yet, other studies report more mixed attitudes among gay men toward seeking professional psychological help. In a study by McClennen, Summers, and Vaughan (2002) of gay male victims of domestic violence they found these victim's help-seeking behaviors were limited to informal sources, not professional help. Other studies suggest gay men with greater gender role conflicts have more negative views toward help seeking and greater levels of anger, anxiety, self-stigmatizing views, and depression than gay men with lower levels of gender role conflicts (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Simonsen, Blazina, & Watkins, 2000). In his dissertation, Simonsen (1998) also found that higher levels of masculine gender conformity among gay men was related to psychological dysfunction, negative views of help seeking, and internalized homophobia.

Gay youth may also experience additional concerns around confidentiality and therapist bias. Williams (2010) found that sexual minority youth reported greater concerns about confidentiality than heterosexual youth and consequently obtain healthcare from private doctors rather than their schools. Furthermore, based on the results of a focus group of 49 college men, Davies et al. (2000) found that not only do men not seek help unless absolutely necessary, but that gay men reported concerns about feeling safe, accepted, understood, and about the competence of the therapist. Moreover, gay men's concerns about help seeking are supported by

a study by Hayes and Erkis (2000) that therapists respond with “less empathy, attributed less responsibility to the client for solving his problems, assessed the client's functioning to be worse, and are less willing to work with the client when the client's source of HIV infection are other than drugs, when the client is gay, and when the therapist is more homophobic” (p. 71).

Although, in general, psychologists have a more positive view of homosexuality than the general population (Green, Murphy, Blumer, & Palmanteer, 2009), several studies support the idea that therapists engage in sexual orientation micro-aggressions within therapy. Shelton and Delgado-Romero (2011) identified seven sexual orientation micro-aggressions in psychotherapy given patient's experiences: “assumption that sexual orientation is the cause of all presenting issues; avoidance and minimizing of sexual orientation; attempts to over-identify with LGBQ clients; making stereotypical assumptions about LGBQ clients; expressions of hetero-normative bias; assumption that LGBQ individuals need psychotherapeutic treatment; warnings about the dangers of identifying as LGBQ” (p. 215). Taken together, these factors may hinder a gay man's desire to seek professional psychological help.

Summary

Internalized homophobia is associated to some degree with the development of physical and psychological challenges. This appears to be particularly true for EAGM. These men are at greater risk for a variety of psychological problems, including depression, anxiety, substance abuse, sexual health problems, and suicidal thoughts and behaviors. Furthermore, when EAGM have higher levels of internalized homophobia they are also at greater risk for increased levels of depression, high levels of anxiety, low levels of self-esteem, increased shame and sexual dysfunction, further substance abuse, a higher potential for suicidal behavior, and more insecure types of attachment. This leaves these individuals at a greater need for psychological services.

While LGBT individuals utilize mental health services more than their heterosexual counterparts, EAGM appear to have more negative views of help seeking, particularly when they do not feel safe in the therapeutic environment and when they conform to ridged masculine gender roles.

Attachment plays an important role in how emerging adults view seeking professional psychological help. Specifically, emerging adults with avoidant/fearful forms of attachment are more likely to have negative attitudes about seeking professional psychological help. More insecure forms of attachment also contribute to higher levels of internalized homophobia. However, little to no research has been done on how EAGM's attachment styles play into their views of seeking professional psychological help. Nor has research studied the connection between internalized homophobia and attitudes toward seeking professional psychological help. Finally, minimal research has been done on the interactional effects of internalized homophobia and attachment on attitudes toward seeking psychological help. This research seeks to understand the effects that attachment and internalized homophobia have on attitudes toward seeking psychological help among EAGM in order to address the gaps in the research and inform practitioners who work with this population in the areas of outreach, treatment planning, and interventions. Specifically the aim of this research is to: (1) assess the relationship between EAGM's attachment style and internalized homophobia; (2) evaluate the relationship between attitudes toward seeking professional psychological help and internalized homophobia among EAGM; (3) examine the relationship between EAGM's attachment style and their attitudes toward seeking professional psychological help; (4) investigate the degree to which internalized homophobia accounts for attitudes toward seeking professional psychological help when other factors are considered.

Chapter III

Methods

This chapter provides an overview of the research design, instrumentation, recruitment procedures, and the data analysis utilized in this study.

Sampling Procedure

A convenience and snowball sampling method was utilized for this study. Gay and/or questioning male participants from age 18 to 28 were recruited through the distribution of fliers (Appendix A) at various locations across the country, such as university LGBT organizations, community LGBT organizations, and gay bars. The author found these various organizations through the internet and reached out to them via email and facebook.com email, asking them to hand out the fliers, to post them on bulletin boards, community forums, and their websites. Approximately 20 locations were contacted, 14 of which were LGBT organizations at various universities, three were community LGBT organizations, and three were gay bars. Only two sites responded or confirmed their willingness to help. Advertisements were also placed on social networking sites such as Reddit.com, Facebook.com, Craigslist.com, and Twitter. Because the author of the current study lives in a region of the U.S. that is less discriminating regarding rights for sexual minorities, there is the potential for over sampling in this geographical region (the Pacific Northwest). Therefore, a concerted effort was made to recruit participants from more conservative areas of the country as measured by U.S. state laws regarding homosexuality. The Human Rights Campaign (HRC) assesses gay rights laws around the U.S. Based on laws of discrimination of LGB individuals in the areas of marriage, employment, housing, school, and hate crime laws, the following states discriminated against LGB individuals in all of these areas: Alabama, Oklahoma, Texas, Louisiana, Mississippi, Tennessee, South Carolina, Georgia,

Florida, Kentucky, Kansas, and Virginia (HRC, 2010). Outreach efforts were made to these states in particular for sampling. Advertisements and participant recruitment was strong in these states both online (i.e., craigslist.com focused on regional areas) and at local universities. These states were targeted because of the increased likelihood participants in these states would harbor higher levels of internalized homophobia based on a social theory model (Allport, 1979; Meyer, 1995).

Participants were asked to visit SurveyGizmo.com, a survey based website, to participate in a research study about their perception of themselves and their attitudes toward mental health services. Pacific University's Institutional Review Board (IRB) approved this study. Upon entry to the website, participants read and acknowledged the study description and were asked to agree to the informed consent form (Appendix B). Participants were asked to fill out four questionnaires: a demographics questionnaire; the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994); the Internalized Homophobia Scale (IHS; Ross & Rosser, 1996); and the Attitudes Toward Seeking Professional Psychological Help – Short Form Scale (ATSPPH-SF; Fischer & Farina, 1995; all measurements are located in Appendices C-F). The study was anonymous in nature. SurveyGizmo assigned an identification number to each participant. Internet Protocol (IP addresses) were not recorded or saved. Participants were not compensated for completing the survey. Furthermore, participants were not debriefed after the study due to its anonymous nature. However, participants were given the researcher's contact information if they wished to receive the results of the study.

Measures

Demographics questionnaire. A demographic questionnaire was designed to gather basic information in a multiple-choice format. The author developed a demographics

questionnaire aimed at generating information about a participants' race, age, sexual orientation, racial background, current state, religious affiliation, religious importance, education level, and current place of residence. The author developed a self-report measure of perceived level of LGBT community support, which was adapted from GLSEN's (2009) survey of LGBT students and their perceived support at school. The one item question was scored on a four point Likert-type scale reverse coded (1 = "Very supportive" to 4 = "Not at all supportive"). The item read: "In general, how supportive do you think people in your community are of LGBT people?"

Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994a & b). The RSQ is a 30-item continuous measure of attachment consisting of four attachment styles: secure, fearful, preoccupied, and dismissing. The RSQ contains statements from Hazan and Shaver's (1987) attachment measure, Bartholomew and Horowitz's (1991) Relationship Questionnaire, and Collins and Read's (1990) Adult Attachment Scale. Participants rate each item on a five point Likert-type scale (1 = "Not at all like me" to 5 = "Very much like me"). Sample items include: "I find it easy to get emotionally close to others." (Secure); "I find it difficult to depend on other people" (Fearful); "I want to be completely emotionally intimate with others." (Preoccupied); and "It is very important to me to feel independent." (Dismissing). Responses are summed within each subscale of attachment with higher scores indicating higher levels in each domain. Griffin & Bartholomew (1994b) found adequate reliability with Cronbach's alphas of $\alpha = .40$ (secure), $\alpha = .70$ (Fearful), $\alpha = .50$, (Preoccupied), and $\alpha = .70$ (Dismissing).

Internalized Homophobia Scale (IHS; Ross & Rosser, 1996). The IHS is a 26-item continuous measure of internalized homophobia. Ross and Rosser (1996) conducted a factor analysis which produced four subscales: public identification as gay; perception of stigma associated with being gay; social comfort with gay men; and moral and religious acceptability of

being gay. Participants rate each item on a seven point Likert-type scale (1 = “Strongly Agree” to 7 = “Strongly Disagree”). Sample items include: “It would not be easier in life to be heterosexual.” (Public); “I worry about becoming unattractive.” (Stigma); “Most of my friends are homosexual.” (Social); and “Homosexuality is not against the will of God.” (Moral). Responses are summed within each subscale of internalized homophobia, with higher scores indicating higher levels of internalized homophobia for each subscale. The 26-item version of the IHS has been tested on a population of 184 men (*M* age of 37 and an *SD* of 9.3 years) who identify as having sex with other men or are attracted to other men. Ross and Rosser (1996) found adequate reliability with Cronbach’s alphas of $\alpha = .85$ (Public), $\alpha = .69$, (Stigma), $\alpha = .64$ (Social) and $\alpha = .66$ (Moral). They also found the scales exhibited significant concurrent validity when compared to a set of criterion measures that were determined from the existing literature to be related to the construct.

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

(ATSPPHS – SF; Fischer & Farina, 1995). The ATSPPHS – SF is a 10 item continuous measurement of attitudes toward seeking professional psychological help. Participants rate each item on a four point Likert-type scale (0 = “Disagree” to 3 = “Agree”). Sample items include: “A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help;” “If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy;” and reverse coded, “The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.” Responses are summed, with higher scores indicating more positive attitudes toward seeking professional psychological help. Fischer and Farina (1995) and Fischer and Turner (1995) found a Cronbach alpha of $\alpha = .84$. Additionally, internal consistency and concurrent

validity have been found across diverse populations, including Asian Americans ($\alpha = .85$) (Kim & Omizo, 2003) and ($\alpha = .81$) in a sample of African, Asian, and Latin American international students (Moore & Constantine, 2005).

Data Analysis

Data were collected on Surveygizmo.com. When data collection was complete, the data were coded and entered into the Statistical Product and Service Solutions Version 19 (SPSS-19) software program. Mean scores were calculated for missing data points. Frequencies and percentages were calculated for various demographic variables (age, sexual orientation, racial background, religious affiliation, religious importance, education level, perceived LGBT community support). Means and standard deviations were calculated for each measure (highest level of education; importance of religious values; level of LGBT Support; public identification as gay; social comfort with gay men; perception of stigma associated with being gay; moral and religious acceptability of being gay; fearful attachment; dismissive attachment; preoccupied attachment; secure attachment; and attitudes toward help seeking). A Pearson product-moment correlation was conducted for research questions one through three to assess the relationship between attachment style and internalized homophobia, attitudes toward seeking professional psychological help, and internalized homophobia, and finally, attachment style and attitudes toward seeking professional psychological help. For research question four, a hierarchical multiple regression was used to see if internalized homophobia helped predict attitudes toward seeking professional psychological help to a greater degree than age, education, and fearful attachment.

Chapter IV

Results

Sample Description

In total, 355 participants started the survey. However, 50 participants did not complete the survey past the demographics questionnaire. Thirty-four participants were disqualified due to not meeting age, gender, and/or sexual orientation criteria. Another 46 participants did not complete the survey past the first scale (Internalized Homophobia Scale). To analyze the differences between those who completed the survey in its entirety and those who did not complete the survey past the IHS, a series of independent samples t-test were conducted to detect demographic differences. No differences were found between the two on any completed scale (see Table 3).

Table 3
Means and Standard Deviations, Results of Independent Samples t-test Analyses of Complete Response Set and Incomplete Beyond IHS

	Incomplete		Complete		<i>t</i> (46/225)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Age	22.98	3.14	23.25	3.14	-.53
Religious importance	3.2	1.0	3.27	.98	-.44
Education level	3.85	1.39	3.99	1.32	-.64
Level of LGBT support	2.13	.86	1.94	.8	1.44
Public identification as gay	3.29	1.15	2.98	1.14	1.65
Social comfort with gay men	3.46	1.29	3.26	1.09	1.15
Perception of stigma associated with being gay	3.75	.62	3.69	.63	.63
Moral and religious acceptability of being gay	2.26	.94	2.24	.88	.17

* $p < .05$

Those individuals who did not complete the survey past the IHS scale or the demographics questionnaire and those who were disqualified due to age, gender, or sexual

orientation were identified and their answers were excluded from the analysis. In total, 225 participants remained and their data formed the basis of the analyses. For those who left answers blank, the researcher filled in missing responses with the mean score for each question (Appendix G). One participant did not report their gender. A mean score was taken and the missing response was filled in as male. However, all participants who completed the survey identified as homosexual (92.9%) or unsure/questioning (7.1%). Ages ranged from 18 to 28 ($M=23.2$, $SD=3.1$). The majority of participants were white/Caucasian (86.2%), 11.2% identified as Latino/Latin American, and 4.9 percent identified as Black/African American. Thirty-eight states were represented with 40% from more affirming states such as New York ($n=36$; 16.7%), Oregon ($n=31$; 14.4%) and California ($n=21$; 9.8%), and 21 percent from discriminatory states (Alabama ($n=3$), Florida ($n=3$), Georgia ($n=3$), Mississippi ($n=5$), Louisiana ($n=7$), Virginia ($n=3$), South Carolina ($n=2$), Kentucky ($n=4$), Kansas ($n=3$), Oklahoma ($n=1$), Texas ($n=10$) and Tennessee ($n=5$)). Most participants identified as either atheist ($n=73$; 32.4%), non-religious ($n=57$; 25.3%), or agnostic ($n=41$; 13.7%), with religious values largely not at all important ($n=125$; 56.3%) in how participants lead their lives. Finally, most participants reported their communities to be somewhat supportive ($n=118$; 52.4%) or very supportive at ($n=66$; 29.3%) of LGBT people. Table 4 summarizes demographic information of respondents.

Table 4
Demographic Information

Demographics	Percentage and Frequency
Age (years) ($N=225$; $M=23.2$) $SD=3.1$	
18-20	23.6% (53)
21-23	29.3% (66)
24-26	28% (62)
27-28	19.6% (44)
Sexual Orientation ($N=225$)	
Homosexual/Gay	92.9% (209)
Unsure or questioning	7.1% (16)
Racial Background ($N=224$)	

Which/Caucasian	86.2% (193)
Hispanic/Latino/Latina American	11.2% (25)
Asian/Asian American	4.9% (11)
Black/African American	1.8% (4)
Rest	2.2% (5)
Religious Affiliation (<i>N</i> =225)	
Atheist	32.4% (73)
None	25.3% (57)
Agnostic	13.7% (41)
Christian	7.6% (17)
Roman Catholic	6.7% (15)
Rest	9.7% (22)
How important are your religious values to the way you lead your life?	
Not at all important	56.3% (125)
Not too important	22.1% (49)
Somewhat important	13.5% (30)
Very important	8.1% (18)
Education Level (<i>N</i> =225)	
Bachelor Degree	38.2% (86)
Some college, no degree	33.3% (75)
Post-graduate degree	10.2% (23)
Graduated high school or equivalent	9.3% (21)
Associate degree	6.2% (14)
12th grade or less	2.7% (6)
In general, how supportive do you think people in your community are of LGBT people?	
Very supportive	29.3% (66)
Somewhat supportive	52.4% (118)
Not too supportive	12.9% (29)
Not at all supportive	5.3% (12)

Descriptive and Bivariate Analysis

Means, standard deviations, and bivariate analyses for each measure are presented in Tables 5 and 6. A Pearson product-moment correlation was computed among the following variables: demographic variables age; highest level of education; importance of religious values; and level of LGBT support; level of internalized homophobia for each (public identification as gay, perception of stigma associated with being gay, social comfort with gay men, and moral and religious acceptability of being gay); each of the four attachment styles (secure, fearful,

preoccupied, and dismissive); and attitudes toward seeking professional psychological help. In total, 78 correlations were computed. Using the Bonferroni approach to control for Type I error across the 78 correlations a p value of less than .001 ($\alpha = .05/78 = .001$) is required for significance. The results of the correlational analysis indicated 24 out of the 78 correlations were statistically significant at a $p < .001$ (see Table 6). In accordance with Cohen (1988), the following guidelines for interpreting correlation coefficients (< 0.1 = insubstantial; 0.1 to 0.3 = small; 0.3 to 0.5 = moderate; 0.5 to 1.0 = large) was used.

Table 5

Measure Means and Standard Deviations

Measures	<i>M</i>	<i>SD</i>
Age	23.2	3.1
Highest level of education	1.73	.98
Importance of religious values	3.01	1.32
Level of LGBT Support	3.06	.80
Public identification as gay	2.92	1.12
Social comfort with gay men	3.25	1.09
Perception of stigma associated with being gay	3.69	.63
Moral and religious acceptability of being gay	2.24	.88
Fearful Attachment	3.04	.98
Dismissive Attachment	3.36	.66
Preoccupied Attachment	3.24	.73
Secure Attachment	2.93	.69
Attitudes Toward Help Seeking	1.83	.63

Age had a large positive correlation with an EAGM's level of education ($r(223) = .54, p < .001$). Age also had a small positive correlation with how supportive an EAGM feels people in their community are toward LGBT individuals ($r(223) = .24, p < .001$), indicating the older an

EAGM is the more LGBT support they view in their community. Finally, Age was positively correlated at a small level with attitudes toward seeking psychological help ($r(223) = .27, p < .001$), indicating that the older a young gay man is, the more likely he is to view seeking psychological help positively.

Education was negatively correlated at a moderate level with how supportive a young gay man feels people in their community are toward LGBT individuals ($r(223) = -.31, p < .001$). Education had a small correlation with attitudes toward seeking psychological help ($r(223) = .21, p < .001$), indicating the more educated an individual is more likely they are to have positive attitudes toward seeking psychological help.

All of the scales in his, except moral (perception of stigma associated with being gay, public identification as gay, and social comfort with gay men), were negatively correlated with how supportive a young gay man feels people in his community are toward LGBT individuals ($r(223) = -.33, p < .001$, $r(223) = -.25, p < .001$, and $r(223) = -.23, p < .001$), representing moderate, small, and small correlations coefficients respectively.

There was a small positive correlation between religious importance to how individuals lead their life and their public identification as gay ($r(221) = .25, p < .001$).

There were five significant correlations among the various Ross and Rosser's IHS subscales. There was a large positive relationship found between one's public identification as gay and social comfort with gay men ($r(223) = .61, p < .001$); perception of stigma associated with being gay representing a moderate positive correlation ($r(223) = .39, p < .001$); and moral and religious acceptability of being gay representing a small positive correlation ($r(223) = .28, p < .001$). There was also a moderate positive correlation between one's social comfort with gay

men and the perception of stigma associated with being gay ($r(223) = .30, p < .001$) and a small correlation between moral and religious acceptability of being gay ($r(223) = .24, p < .001$).

Of the six correlations in the RSQ four were significant. There was a moderate positive relationship found between fearful attachment and dismissing ($r(223) = .40, p < .001$). The more fearfully attached a participant is the more dismissing they are likely to be. There was a large negative correlation between fearful attachment and secure ($r(223) = -.65, p < .001$). The more securely attached an individual is the less likely he is to be fearfully attached. Yet, the more dismissing an individual is the less preoccupied and secure he is ($r(223) = -.32, p < .001$. $CI = -.44$ and $r(223) = -.19, -.29, p < .001$), respectively.

With regard to internalized homophobia and attachment, seven of the sixteen correlations were statistically significant. Fearful attachment was positively correlated with each subscale of the internalized homophobia measure except moral and religious acceptability of being gay, with public identification as gay rated at ($r(223) = .38, p < .001$); social comfort with gay men gay ($r(223) = .40, p < .001$); and perception of stigma associated with being gay ($r(223) = .31, p < .001$). The more fearfully attached a young gay male is the less likely he is to identify as gay, to feel comfortable around gay men, and the more likely he is to feel stigmatized for being gay. Furthermore, there was a positive correlation between preoccupied attachment and social comfort with gay men ($r(223) = .20, p < .001$). There were no significant correlations between the various scales of internalized homophobia and dismissing attachment.

There was a negative correlation between all of the internalized homophobia and secure attachment scales except moral and religious acceptability of being gay. Secure attachment and public identification as gay and secure attachment were negatively correlated ($r(223) = -.24, p < .001$); secure and social comfort with gay men ($r(223) = -.42, p < .001$); secure and perception of

stigma associated with being gay ($r(223) = -.31$ $p < .001$). In sum, EAGM with higher levels of discomfort identifying as gay were less securely attached.

Finally, there was a negative correlation found between attitudes toward seeking professional psychological help and perception of stigma associated with being gay ($r(223) = -.24$ $p < .001$). This indicates that the more a young gay man perceives stigma the less favorable his views on seeking psychological help will be. The correlation matrix is presented in Table 6.

Table 6

Correlations Among, Demographic Variables, internalized homophobia, attachment style, and attitudes toward help seeking professional psychological help (N = 225) (95% confidence intervals)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Age	--												
2. Highest level of education	.63**	--											
3. Importance of religious values	.06	-.09	--										
4. Level of LGBT Support	.24**	.31**	-.03	--									
5. Public identification as gay	-.07	-.10	.25**	-.25**	--								
6. Social comfort with gay men	-.16*	-.18**	.14*	-.23*	.61**	--							
7. Perception of stigma associated with being gay	-.09	-.15*	.01	-.33**	.39**	.30**	--						
8. Moral and religious acceptability of being gay	-.02	-.10	.04	-.09	.28**	.24**	.10	--					
9. Fearful	-.12	-.10	.01	-.04	.38**	.40**	.31**	.08	--				
10. Dismissing	-.05	.048	.04	.15*	-.02	-.00	.06	-.01	.40**	--			
11. Preoccupied	-.17*	-.12	-.004	-.14*	-.15*	.20**	.12	-.11	.16*	-.32**	--		
12. Secure	.06	.07	.04	.14*	-.38**	-.42**	-.31**	-.01	-.65**	-.29**	-.13	--	
13. Attitudes Toward Seeking Professional Psychological Help	.27**	.21*	.03	.13	-.22*	-.11	-.24**	-.15*	-.14*	-.05	.02	.01	--

* $p < .05$ ** $p < .001$

Regression Analysis

A hierarchical multiple regression was used to see if internalized homophobia helped predict attitudes toward seeking professional psychological help above and beyond all other statistically significant variables: age and fearful attachment. Dismissing, preoccupied, and secure attachment, as well as a participants' level of education, perception of LGBT support, religious importance, and the IHS scale of social comfort with gay men, were not significantly correlated with attitudes toward seeking professional psychological help and were left out of the regression. Age and the IHS scale of perception of stigma associated with being gay were significant after the Bonferroni correction and were entered into the model. Although fearful attachment was not significantly correlated with attitudes toward help seeking after accounting for the Bonferroni correction, fearful attachment was included in the model because previous research shows a connections between fearful attachment and more negative attitudes toward seeking professional psychological help (Vogel & Wei, 2005; Lopez, et al., 1998; Feeney & Ryan, 1994). Furthermore, despite not being statistically significant after a Bonferroni correction, the IHS of public identification as gay and moral and religious acceptability of being gay were added to the model because the purpose of the paper is to explore internalized homophobia, and correlations were significant at the $p < .05$ level.

The regression model consisted of three stages in which the following variables were entered: Step 1) age; Step 2) fearful attachment; Step 3) the internalized homophobia scales of religious acceptability of being gay, public identification as gay were entered, as well as the perception of stigma associated with being gay. The results of step one indicated that the variance accounted for (ΔR^2) with age equaling .07 (adjusted $R^2=.07$), which was significantly different from zero ($\Delta F(1;223)=17.08, p<.001$). In step two, fearful attachment was entered into

the regression equation. The change in variance accounted for (ΔR^2) was equal to .01, which was not a statistically significant increase in variance accounted above the variability contributed by the previous predictor variables entered in step one. In step three, the IHS of public identification as gay, moral and religious acceptability, and the perception of stigma associated with being gay were entered. The change in variance accounted for (ΔR^2) was equal to .06 (adjusted $R^2=.12$), which was a statistically significant increase in variance accounted above the variability contributed by the previous predictor variables entered in step two ($\Delta F(3;219)=4.98, p<.01$). The total variance accounted for by all three models was 14 percent. The two measures that were statistically significant in the model were age and the IHS subscale of the perception of stigma associated with being gay. Those younger in age and those with higher levels of stigma associated with being gay had more negative attitudes toward seeking professional psychological help. Table 7 shows the results of the hierarchical multiple regression analysis.

Table 7

Regression Analysis Examining Age, Fearful Attachment, and Internalized Homophobia Scales

Variable	Model 1			Model 2			Model 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	.05	.01	.27**	.05	.01	.25**	.05	.01	.24**
Fearful Attachment				-.07	.04	-.11	-.01	.04	-.02
Public identification as gay							-.06	.04	-.16
Perception of stigma associated with being gay							-.16	.07	-.16*
Moral and religious acceptability of being gay							-.07	.05	-.10
Degrees of Freedom	1;223			1;222			4;219		
ΔF	17.08			3.01			4.98		
ΔR^2	.07**			.01			.06**		
Total R^2							.14**		

* $p < .05$ ** $p < .01$

Chapter V

Discussion

Review of the Findings

The present study was designed to test the relationship between internalized homophobia, attachment style, and attitudes toward seeking professional psychological help among young gay or questioning/unsure men ages 18-28. The purpose of this study is to: (1) assess the relationship between EAGM's attachment style and internalized homophobia; (2) evaluate the relationship between attitudes toward seeking professional psychological help and internalized homophobia among EAGM; (3) examine the relationship between EAGM's attachment style and their attitudes toward seeking professional psychological help; and (4) investigate the degree to which internalized homophobia accounts for attitudes toward seeking professional psychological when other factors are considered. Consistent with previous research, the present study found a positive correlation between internalized homophobia and more insecure forms of attachment and a negative correlation with secure attachment except for the scale of moral and religious acceptability (Sherry, 2007; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Simonsen, Blazina, & Watkins, 2000; Simonsen, 1998). Also consistent with previous research on attachment the present study found a small positive correlation between attachment and attitudes toward help seeking (Lopez et al.'s 1998; Dozier, 1990; Vogel & Wei, 2005; Feeney & Ryan, 1994; Collins & Feeney, 2000). In a hierarchical linear regression internalized homophobia (Perception of stigma associated with being gay) was statistically significant in accounting for seven percent of the variance in Attitudes Toward Seeking Professional Psychological Help Scale-Sort Form (ATSPPHS-SF) scores when age and fearful attachment were considered; age was the only other variable that was significantly associated with help

seeking. The following section will review the results, limitations, future directions for research, and implications for therapists.

Internalized Homophobia

Age and internalized homophobia. Although it is possible to assume that younger individuals would have higher levels of internalized homophobia because they are early in the coming out stages (Landa & Bybee, 2007), the present study found age among EAGM to not be related to internalized homophobia. Consistent with this finding, previous research has found similar results among young gay black men (Amola, 2011). Several aspects may contribute to this finding. Gay individuals are recognizing- their sexuality at a younger age (Drasin, Beals, Elliot, Lever, Klein & Schuster, 2008; Savin-Williams, & Diamond, 2000; Savin-Williams, 1995). This may prompt these individuals to grapple with their homosexuality before age 18. Furthermore, 40% of participants in the present study reside in New York, Washington, and California. These states generally hold more liberal attitudes toward homosexuality, which may mitigate some of the negative effects associated with coming out and self-hatred (HRC, 2010). Future research should include more stigmatized areas.

Education and internalized homophobia. Higher levels of education and more positive views of homosexuality have been highly correlated (Denny, 2011; Flood & Hamilton, 2008; Stulhofer & Rimac, 2009). However, the present study's results are mixed on levels of education and internalized homophobia. With regards to the IHS scales, only one was found to be statistically significant. There was a small but significant negative correlation between education and the IHS scale of social comfort with gay men. Future research should focus on how education can be used to not only mitigate homophobia in general but also internalized homophobia among EAGM.

Importance of religious values and internalized homophobia. Among the general population religion has been found to be largely helpful in terms of “psychological health, including less depression and psychological distress, greater life satisfaction, personal happiness, and psychological well-being” (Barnes & Meyer, 2012, p. 505). Yet, most religions in the United States condemn same-sex behavior (Pew Forum on Religion and Public Life [Pew], 2008).

Based on the minority stress theory and non-supportive religious environments, it was expected that higher levels of religious importance would show increased rates of internalized homophobia. Consistent with this theory, research has found that exposure to higher rates of non-affirming religious denominations among white, black, and Latino LGB individuals is correlated with higher levels of internalized homophobia (Barnes & Meyer, 2012). However, the results of the present study were mixed. While the IHS provided a scale of moral and religious acceptability of being gay, it was not associated with a young gay man’s self-reported importance of religion in how they lead their lives. Interestingly, but not surprisingly, there was a positive correlation between a young gay man’s public identification as gay and the importance religion plays in how he leads his life. This suggests an internal struggle with publically acknowledging one’s homosexuality and the internal importance religion plays, which is consistent with the minority stress theory. EAGM may feel the pressure of their religious institutions to not publicly share their homosexuality.

Attachment and internalized homophobia. Various studies have found a relationship between more insecure forms of attachment and internalized homophobia, particularly fearful/avoidant and preoccupied attachment (Brown & Trevethan, 2010; Sherry, 2007; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Simonsen, Blazina, & Watkins, 2000; Simonsen, 1998). Consistent with previous research the present study found both a positive

correlation between internalized homophobia and fearful attachment and a negative correlation with secure attachment in every domain except moral and religious acceptability of being gay. Preoccupied attachment and the IHS subscale of social comfort of being gay also had a small but significant positive correlation. This suggests that EAGM with higher levels of internalized homophobia will also have higher levels of fearful attachment and lower levels of secure attachment.

Internalized homophobia and attitudes toward seeking professional psychological help. Little research has been done on internalized homophobia and attitudes toward seeking psychological help. Gay men who express rigid adherence to gender roles often have high levels of anger, anxiety, depression, and self-stigmatizing views of themselves leading to negative views of help seeking (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Simonsen, Blazina, & Watkins, 2000). Each of these constructs is correlated with higher levels of internalized homophobia (Allen & Oleson, 1999; Meyer, 1995). The present study found the IHS subscale of perception of stigma associated with being gay to be related to more negative views of seeking psychological help. Since no previous research has been done to clarify the association between internalized homophobia and help seeking behaviors further research should be done to evaluate and replicate these findings.

Attachment

Age, education, religious importance, level of LGBT support, and attachment. Age, level of education, importance of religious values, and level of LGBT support were not associated with attachment in the present study.

Attachment and attitudes toward seeking professional psychological help. The present study found no significant correlation at the $<.001$ level between any attachment style

and attitudes toward seeking professional psychological services. However, fearful had a small negative correlation at the $<.05$ level. Shaffer, Vogel, and Wei (2006) also found a small negative correlation between avoidant attachment and ATSPPHS – SF at the .05 level (-.10 their study; -.14 my study). While previous research has found a correlation between fearful attachment and the help-seeking construct different measurements have illuminated different results (Lopez et al.'s 1998; Dozier, 1990; Vogel & Wei, 2005; Feeney & Ryan, 1994; Collins & Feeney, 2000). For example, Lopez et al.'s (1998) study found a correlation between fearfully attached college students and lower scores on the Willingness to Seek Counseling measure. However, they did not find a significant correlation when using the ATSPPHS – SF (the measurement utilized in the present study). Lopez et al. found little correlation between the two measures, suggesting separate constructs. They noted the ATSPPHS might have only assessed a “general orientation toward therapeutic help seeking,” while the willingness measure “directed respondents to indicate their own orientation toward pursuing counseling should problems arise in their lives” (p. 82). They hypothesized the more personal nature of the willingness measure of asking students to indicate their willingness to seek counseling for each of the 20 problem items might have “activate[d] respondents' core expectations of the potential trustworthiness and dependability of others” (p. 82). However, the authors did not include the source of the willingness measure nor any psychometric properties. Future research should utilize scales such as the willingness scale given its ability to detect a correlation due to its focus on the person in therapy, not just their attitudes toward therapy.

Attitudes Toward Seeking Professional Psychological Help

Age. Previous research has found that in the general younger individuals are less likely to seek psychological services (Vogel, Gentile, & Kaplan, 2008; Vogel, Wade, & Hackler, 2008).

Furthermore, many studies have documented that men in general, regardless of age, race, nationality, or ethnic identity, are less likely to seek psychological help than women (Husaini, Moore, & Cain, 1994; McKay, Rutherford, Cacciola, & Kabasakalian-McKay, 1996; Padesky & Hammen, 1981). This is particularly true for young men (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Similar to these findings, the present study found that younger EAGM have more negative attitudes toward seeking psychological help.

Model Summary

A hierarchical multiple regression was used to see if internalized homophobia helped predict attitudes toward seeking professional psychological help above and beyond age, education, and fearful attachment. Consistent with the fourth hypothesis, internalized homophobia, specifically, stigma associated with being gay, helped predict attitudes toward seeking psychological help above and beyond age and fearful attachment. These findings suggest that when EAGM perceive stigma associated with being gay their attachment style do not account for their negative attitudes toward seeking psychological help. This seems particularly true among younger EAGM.

However, there are several limitations to this finding. While internalized homophobia was statistically significant in accounting for seven percent of the variance in ATSPPHS scores when age, education, and fearful attachment were considered, age was the only other variable that was statistically significant. Given the Bonferroni correction the present study found a small, non-significant negative correlation between fearful attachment and attitudes toward help seeking. Thus, when placing fearful attachment into the hierarchical regression, there was not a significant change. Education level, public identification as gay, social comfort with gay men, and moral and religious acceptability of being gay did not significantly add to the model either.

In order to make this finding more robust future studies should utilize a help seeking measurement that taps into the participant's own orientation toward seeking psychological help.

Implications for Therapists

Given the present study's findings associating fearful attachment and higher levels of internalized homophobia in EAGM, as well as the role perception of stigma plays in EAGM's attitudes toward seeking psychological help, there are several implications for therapists. Therapy can provide a place where individuals can challenge negative views of themselves while developing a relationship with the therapist that can change their attachment style (Levy et al., 2006). This may lead to EAGM having a more empowered sense of self and to being less likely to internalize society's stigmatizing views. Throughout the next section I will review each domain and describe the potential implications for therapists.

Stigma and internalized homophobia. Therapists should ideally create a non-threatening and non-stigmatizing therapeutic environment, helping EAGM who feel stigmatized to become more comfortable and more apt to share personal struggles with the therapist. This may include having LGBT supportive literature in the waiting room, a bulletin board featuring LGBT events, and a resource guide for LGBT individuals. The therapist may also elect to volunteer at local LGBT events, actively support pro-LGBT legislation, or be a member of an LGBT association (such organizations could include: Parents, Families and Friends of Lesbian and Gays (PFLAG); Gay and Lesbian Medical Association (GLMA); American Psychological Association's (APA) division 44: Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues, or other local organizations). Therapists should also use gender-neutral terms such as partner or date. This helps avoid heterosexist assumptions and also gives the client room to self-identify as who they are. Similarly, these clients may enter therapy with numerous

presenting concerns such as family conflict, anxiety, suicide, substance abuse, and relationship difficulties (Coleman & Remafedi, 1989). Therefore, it is important that therapists do not overly focus on sexuality issues as this may leave the patient feeling their sexuality is the sole cause of their problems, serving to only further stigmatize them and push them away from therapeutic attachment (Shelton & Delgado-Romero, 2011).

Finally, therapists can be an active voice in their community about the impact internalized homophobia has on EAGM. This will help educate other mental health professionals and service providers (including teachers, parents, therapists, social workers, researchers, and government officials) of the impact stigma can have on an EAGM and ways to mitigate the effects.

Fearful attachment, internalized homophobia, and help seeking. While the present study did not find a significant association between fearful attachment and help seeking behaviors, previous research has (Lopez et al.'s 1998; Dozier, 1990; Vogel & Wei, 2005; Feeney & Ryan, 1994; Collins & Feeney, 2000). Attachment is instrumental in how individuals view themselves and others, including assumptions and motives regarding other people's behaviors. This leads individuals to act, or rather react, in their lives regarding these perceived assumptions (Siegel, 1999; Bowlby, 1973; Wallin, 2007). Therapy is one way individuals can change or alter their attachment style, thus altering their internal and external assumptions of worthiness and lovability (Levy et al., 2006).

In the present study fearfully attached individuals were more likely to have higher levels of internalized homophobia, particularly among less educated and younger EAGM creating an impetus for therapeutic intervention on two fronts: fearful attachment and internalized homophobia. Addressing these issues can be done in several ways. Suggestions for working with

EAGM who have high levels of stigma associated with being gay are presented above. Working with fearfully attached individuals can be a difficult endeavor for therapists given these individuals' negative attitudes toward help seeking and denial of psychological problems. Similar to working with stigmatized individuals, therapists should engage in innovative and creative outreach programs for younger, less educated EAGM aimed at psychological education regarding therapy. When providing outreach, therapists should avoid pathologizing language. They can focus on how many young adults go through difficult times highlighting various transitions such as moving, relationship difficulties, and family disagreements. Even if an EAGM has a less than optimal attachment pattern they can still be informed they don't have to struggle alone. This, in and of itself, will help stigmatized individuals and those who have fearful attachment start the corrective attachment process. Having a therapist reach out to them and be curious about their fears and emotions provides a contradiction to their attachment style, with an assumption that others are not safe nor can others help with their difficulties.

Overall recommendations. The impact of perceived stigma, fearful attachment, and lower levels of education among younger EAGM is complex. However, with proper training and an affirmative therapeutic stance therapists can effectively reach out to and engage these individuals in therapeutic services. Table 6 provides recommended therapeutic activities based on the present study's findings and was adapted from the APA's Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (2012).

Table 6

Suggested Therapeutic Activities for working with stigmatized and fearfully attached EAGM

1. Provide outreach to younger EAGM around mental health focusing on the destigmatization of being gay
2. Provide an open and supportive environment for LGBT individuals
3. Be collaborative with patients, understand their beliefs and values, and do not assume all LGBT experiences are the same

4. Therapists should familiarize themselves with their patient's community and the level of support available to them
 5. Therapist should be flexible and understanding of their patient's sexual orientation and sexual behaviors
 6. Provide psychological education around the nature of internalizing stigma, while validating the patients lived experiences
 7. Encourage relational development where vulnerabilities and fears can be expressed without criticism or judgment from the therapist
 8. Help engage the patient in developing non-stigmatizing relationships
 9. Provide a secure based from which the patient can explore these non-stigmatizing relationships with the knowledge they can return to a non-judgmental therapist
 10. Support and encourage the patient to process their emotions
-

Limitations and Future Directions

Sampling limitations. Based on the minority stress theory, particular attention was given to advertisements in the South where states were assessed as discriminatory of gay rights (HRC, 2010). Both local internet forums and campus LGBT groups were targeted for advertisement. Despite this effort only 21% of participants were from discriminatory states, while 40% were from more affirming states such as New York, Oregon, and California. This may mitigate the generalizability of this study's findings because of the disproportionate number of participants from more gay affirming states. These individuals many not face the same level of internal challenges to being gay as those from less affirming states, because they are less likely to be exposed to a higher magnitude of homophobia and heterosexism. Further research should be concentrated in these less affirming areas.

Studying internalized homophobia is a difficult endeavor. There are several aspects that limit the generalizability of this study to EAGM. Among them is that internalized homophobia limits a person's ability to even recognize his minority sexuality, and thus likely limits his ability to participate in studies on internalized homophobia (Brown & Trevethan, 2010; Harry, 1990;

Nungesser, 1983). Additionally, those who are more willing to answer questions about their sexuality may skew toward lower levels of internalized homophobia.

Inherent to internet survey methodology, only those who have access or utilize the internet are represented in this sample. Thus, the present study's results may not be representative of all EAGM (Andrews, Nonnecke, & Preece, 2003). However, Ross, Tikkanen, and Mansson (2000) point to the internet as a sampling strength when sampling gay men as this method is more capable of reaching younger gay men.

Furthermore, approximately 20 locations were contacted, 14 of which were LGBT organizations at various universities: three were community LGBT organizations and three were gay bars. I included the flier in the email or facebook.com email and only two sites responded or confirmed their willingness to help. One of the sites that responded said they would put fliers up. However, they did not follow through. Therefore, it is difficult to gauge if these sites followed through on posting fliers and how many participants were recruited through this method. However, after posting on Reddit.com, Facebook.com, Craigslist.com, and Twitter there were upsurges in the number of completed survey responses. It is likely most of the survey responses came from these sources and not local LGBT organizations. This further limits the generalizability of the present study to those who navigate to the sites where the survey was posted.

Another limitation to this study is the lack of racial diversity. It is difficult to generalize these findings to ethnic minorities given that over 85% of participants in the present study identified as white. Future research should make a concerted effort to recruit racial minorities, creating a more representative sample. Similarly, 20% of the participants in the present study identified a religious affiliation. While LGBT individual are less religious than the general

population (Herek, Norton, Allen, & Sims, 2010; Sherkat, 2002), future research should make an effort to reach these individuals. Finally, the present study utilized a convenience sampling technique that may limit the generalizability of the results.

There were several limitations to the findings regarding the importance religion plays in an EAGM's life. With only 24% reporting a religion, other, or declining to answer, and 26% reporting religion as very important to somewhat important in their lives, it may be difficult to draw conclusions about the relationship between religion and publically acknowledging one's homosexuality. Yet, this is consistent with previous research. Homosexuals are less likely to attend church than heterosexuals, even among homosexuals who consider themselves religious (Herek, Norton, Allen, & Sims, 2010; Sherkat, 2002). Future research should address these limitations by focusing advertising to include religious organizations.

Finally, the present study was limited to young men who self-identify as either gay or questioning. Those who identified as lesbian or bisexual were not included in the study. Thus, these results cannot be generalized to the LBT population. Lesbian, bisexual, and transgendered individuals represent distinct populations with their own barriers to psychological help. Future research should look at ways in which these individuals view and engage in psychological services.

Measurement limitations. There were several limitations in the instruments used. The measurement of perceived community support of LGBT individuals was based on a single question, which read: "In general, how supportive do you think people in your community are of LGBT people?" This was scored on a 1-4 Likert-type scale. The question was not subjected to psychometric examination, thus limiting the reliability and validity of scores generated from this question. The same limitation exists for the question: "How important are your religious values

to the way you lead your life?” Further research should incorporate a measurement that has been subjected to psychometric examination.

As stated above, the ATSPPHS – SF only generated a small correlation with fearful attachment. Previous research found similarly small correlations using the same scale (Shaffer, Vogel, & Wei, 2006). However, when an assessment geared toward directing “respondents to indicate their own orientation toward pursuing counseling should problems arise in their lives,” fearful attachment had a significant correlation (Lopez et al., 1998, p.82). However, the authors did not include the source of the willingness measure nor any psychometric properties. Future research should utilize scales which assess the participants own orientation toward pursuing psychological help given its ability to detect a correlation due to its focus on the person in therapy not just attitudes.

The IHS measure did not provide means or standard deviations for their normed sample (Ross & Rosser, 1996). This represents an inherent limitation in the IHS’ utility. It is difficult to say the current sample represents both those with high and low levels of internalized homophobia when there is not a baseline to compare the current sample to. Furthermore, given that the IHS was developed in 1996, an updated scale of internalized homophobia could detect internalized homophobia more accurately in future research.

Future directions. Given the stigmatizing nature of being gay and the inherent limitations of stigmatized individuals in participating in research (Brown & Trevethan, 2010; Harry, 1990; Nungesser, 1983), future research should incorporate new and innovative ways of sampling this population.

Attitudes toward help seeking appear to become more positive as EAGM get older. However, neither attachment styles nor levels of internalized homophobia appear to change as

EAGM age. Future research could assess whether internalized homophobia and attachment styles change after psychotherapy. Furthermore, research could inquire if these individuals have sought therapy in the past, if they viewed it as helpful, and the impact therapy had on their levels of internalized homophobia and attachment style. This is particularly important in assessing the utility and effectiveness of therapy with EAGM with higher levels of internalized homophobia and fearful attachment.

Based on the present study outreach is particularly needed for younger EAGM with higher levels of perceived stigma associated with being gay as they are less likely to view psychological services as a viable means of help. However, just because these individuals do not view professional psychological help positively does not mean they are not reaching out in others ways. Thus, research integrating creative and culturally appropriate outreach is indicated, including an investigation of how these EAGM are solving their problems.

Finding out why younger EAGM have more negative attitudes toward seeking professional psychological help will be instrumental to providing culturally competent services. This may take the form of a qualitative study inquiring in more depth about their attitudes toward seeking professional psychological help, the methods or approaches by which they currently solve problems, and how therapists can better serve these individuals.

Building on these results it will be important to look at how therapists can provide services to this population. Specifically, given that a therapist cannot know their patient's attachment style and level of internalized homophobia prior to therapy, future research could focus on how on to assess for stigma and fearful attachment while also analyzing how to recruit and retain these individuals in therapy.

Conclusion

The present study added to the research on EAGM with respect to internalized homophobia, attachment, and attitudes toward seeking professional psychological help. The study found that younger and less educated EAGM who are fearfully attached and who perceive stigma associated with being gay view psychological help negatively. Building on previous research, this study provides information to help mental health professions assess and offer outreach to the EAGM community. It demonstrates the need for therapists and researchers to provide outreach and community support to younger adults with the aim of educating them about mental health services while de-stigmatizing being gay. When presented with more open and affirming environments, EAGM are potentially more apt to view services and themselves in a positive light.

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Appendices

Appendix A

Flier

Gay Male Participants (ages 18-28) **Wanted for 15 Min online Survey**

If you are a gay male over the age of 18 and under the age of 28, and you have access to the Internet I invite you to participate in a research study about your attitudes and perceptions.

It will take approximately 15-min to complete and is entirely anonymous. Just log on to <http://edu.surveymizmo.com/s3/1017486/A-Survey-of-Young-Gay-Men> to complete the survey.

Your help is greatly appreciated!

Appendix B

Informed Consent

A survey of gay men, 18 to 28, inquiring about their attitudes toward psychological help seeking,
127-12

1. Study personnel:

Simon J. C. Quartly, MS- Principal Investigator- Pacific University-School of Professional
Psychology- squartly@pacificu.edu

Robin L. Shallcross, PhD, ABPP- Faculty Advisor- Pacific University- School of Professional
Psychology- shallcr@pacificu.edu

Kris L. Gowen, PhD, EdM- Reader- Portland State University- Regional Research Institute-
gowen@pdx.edu

2. Study invitation, purpose, location, and dates: You are invited to participate in a research
study on young gay men's attitudes toward seeking psychological help. The project has been
approved by the Pacific University IRB and will be completed by July 2013. The study will take
place online. The results will be used to inform mental health professionals how to better serve
the young gay male population.

3. Participant characteristics and exclusionary criteria: Only men who self identify as gay or
unsure/questioning are asked to participate in the study. Individuals must be over the age of 18
and under the age of 28 to participate. Potential participants will be asked to excuse themselves
from the study if: they are under the age of 18, female, heterosexual, cannot read at an 8th grade
level, cannot see, hear, or comprehend the English language.

4. Study materials and procedures: If you choose to participate, you will be directed to an online
survey. The survey will ask you to fill out some demographic information, then the website will

prompt you fill out three surveys about yourself in a multiple-choice/Likert scale format. The survey will take approximately 15-20 minutes to complete. Your participation will not cost you anything. The total number of participants is unknown.

5. Risks, risk reduction steps and clinical alternatives: a.) Unknown risks it is possible that participation in this study may expose you to currently unforeseeable risks. b.) Anticipated risks and strategies to minimize/avoid: Risks (social, legal, financial, emotional, etc.) are minimal, no more than those normally encountered in daily life. However, you may be uncomfortable answering some questions. Your responses are anonymous and you may choose to withdraw at any time or may leave specific questions blank. If some questions are not answered, those that are will still be used to inform the study. c.) Advantageous clinical alternatives: This study does not involve experimental clinical trial(s).

6. Adverse event handling and reporting plan: The IRB office will be notified by the next normal business day if minor adverse events occur. The IRB office will be notified within 24 hours if major adverse events occur.

7. Direct benefits and/or payment to participants: a.) Benefit(s) There is no direct benefit to you as a study participant. b.) Payment(s) or reward(s) Participants will not be paid for their participation.

8. Promise of privacy: This study will not prompt you to enter your name or any other identifying information and the results are anonymous. Protecting the privacy of your answers is important to us. The information collected from the surveys will be stored in a password-protected file on a password-protected computer that is not available for public use.

9. Medical care and compensation in the event of accidental injury: During your participation in this project it is important to understand that you are not a Pacific University clinic patient or

client, nor will you be receiving complete medical care as a result of participation in this study. If you are injured during participation in this study and it is not due to negligence by Pacific University, the researchers, or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the researchers, or any organization associated with the study.

10. Voluntary nature of the study: Your decision whether or not to participate will not affect your current or future relations with Pacific University. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences. You can withdraw from the study at any time by exiting out of the web browser.

11. Contacts and questions: The researcher(s) will be happy to answer any questions you may have at any time during the course of the study. If you are not satisfied with the answers you receive, please call Pacific University's Institutional Review Board, at (503) 352-1478 to discuss your questions or concerns further. If you become injured in some way and feel it is related to your participation in this study, please contact the investigators and/or the IRB office. All concerns and questions will be kept in confidence. You are encouraged to print out this form for your records, including the study's personnel and IRB office contact information. Please contact the principle investigator for a hard copy of this form.

12. Statement of consent: I have read and understand the above. I have read and understand the description of my participation duties. All my questions have been answered. I am 18 years of age or over and agree to participate in the study. I agree to participate in this study and understand that I may withdraw at any time without consequence. I have been offered a copy of this form to keep for my records.

Appendix C

Demographic Questionnaire

How old are you? drop down window:

under 18 | 1

18 | 18

19 | 19

20 | 20

21 | 21

22 | 22

23 | 23

24 | 24

25 | 25

26 | 26

27 | 27

28 | 28

29 and above) | 2

What is your identified race (Please check as many as apply to you):

Black/African American | 1

American Indian/Alaska Native | 2

Asian/Asian American | 3

Hispanic/Latino/Latina American | 4

Native Hawaiian or other Pacific Islander | 5

White/Caucasian | 6

Other | 7

Decline to Respond | 8

Gender:

Male | 1

Female | 2

Other | 3

What is your sexual orientation?

Homosexual/Gay | 1

Unsure or questioning | 2

Heterosexual/Straight | 3

In which state do you currently reside?- Drop down selection

Alabama | 1

Alaska | 2

Arizona | 3

Arkansas | 4

California | 5

Colorado | 6

Connecticut | 7

Delaware | 8

District of Columbia | 9

Florida | 10

Georgia | 11

Hawaii | 12

Idaho | 13

Illinois | 14

Indiana | 15

Iowa | 16

Kansas | 17

Kentucky | 18

Louisiana | 19

Maine | 20

Maryland | 21

Massachusetts | 22

Michigan | 23

Minnesota | 24

Mississippi | 25

Missouri | 26

Montana | 27

Nebraska | 28

Nevada | 29

New Hampshire | 30

New Jersey | 31

New Mexico | 32

New York | 33

North Carolina | 34

North Dakota | 35

Ohio | 36

Oklahoma | 37

Oregon | 38

Pennsylvania | 39

Puerto Rico | 40

Rhode Island | 41

South Carolina | 42

South Dakota | 43

Tennessee | 44

Texas | 45

Utah | 46

Vermont | 47

Virginia | 48

Washington | 49

West Virginia | 50

Wisconsin | 51

Wyoming | 52

What is your religious affiliation?

Protestant Christian | 1

Roman Catholic | 2

Evangelical Christian | 3

Christian | 4

Jewish | 5

Muslim | 6

Hindu | 7

Buddhist | 8

Mormon | 9

Agnostic | 10

Atheist | 11

None | 12

Other | 13

Decline to answer | 14

How important are your religious values to the way you lead your life (Reversed Scored)

Very important | 1

Somewhat important | 2

Not too important | 3

Not at all important | 4

What is your highest level of education at this time?

12th grade or less | 1

Graduated high school or equivalent | 2

Some college, no degree | 3

Associate degree | 4

Bachelor's degree | 5

Post-graduate degree | 6

In general, how supportive do you think people in your community are of LGBT people?

(Reverse Scored)

Very supportive | 1

Somewhat supportive | 2

Not too supportive | 3

Not at all supportive | 4

Appendix D

Internalized Homophobia Scale

Please rate the following questions honestly as honestly as you can:

Strongly Agree | 1

Moderately Agree | 2

Slightly Agree | 3

Neither Agree or Disagree | 4

Slightly Disagree | 5

Moderately Disagree | 6

Strongly Disagree | 7

1. Obviously effeminate homosexual men make me feel uncomfortable.-**R -PUB**
2. I prefer to have anonymous sexual partners.- **R Social Comfort**
3. It would not be easier in life to be heterosexual. **PUB**
4. Most of my friends are homosexual. **Social Comfort**
5. I do not feel confident about making an advance to another man. – **R- Social Comfort**
6. I feel comfortable in gay bars. **Social Comfort**
7. Social situations with gay men make me feel uncomfortable. – **R - Social Comfort**
8. I don't like thinking about my homosexuality. – **R -PUB**
9. When I think about other homosexual men, I think of negative situations. – **R - Social Comfort**
10. I feel comfortable about being seen in public with an obviously gay person. **PUB**
11. I feel comfortable discussing homosexuality in a public setting. **PUB**
12. It is important to me to control who knows about my homosexuality. – **R- PUB**

13. Most people have negative reactions to homosexuality. – **R - STIG**
14. Homosexuality is not against the will of God. **MORAL**
15. Society still punishes people for being gay. – **R - STIG**
16. I object if an anti-gay joke is told in my presence. **MORAL**
17. I worry about becoming old and gay. – **R - STIG**
18. I worry about becoming unattractive. **STIG**
19. I would prefer to be more heterosexual. – **R- PUB**
20. Most people don't discriminate against homosexuals. **STIG**
21. I feel comfortable about being homosexual. **PUB**
22. Homosexuality is morally acceptable. **MORAL**
23. I am not worried about anyone finding out that I am gay. **PUB**
24. Discrimination against gay people is still common. **STIG**
25. Even if I could change my sexual orientation, I wouldn't. **PUB**
26. Homosexuality is as natural as heterosexuality. **MORAL**

Higher scores equal higher levels of internalized homophobia

Reverse score: 1, 2, 5, 7, 8, 9, 12, 13, 15, 17, 19

Four Scales:

Public identification as gay (Homo_Pub_(# 1-10)): 1, 3, 8, 10, 11, 12, 19, 21, 23, 25

Perception of stigma associated with being gay (Homo_Stig_(#1-6)): 13, 15, 17, 18, 20, 24

Social comfort with gay men (Homo_Soc_(#1-6)): 2, 4, 5, 6, 7, 9

Moral and religious acceptability of being gay (Homo_Mor_(#1-4)): 14, 16, 22, 26

Appendix E

Relationship Scales Questionnaire

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships. □

Not at all like me 1 | 1

2 | 2

Somewhat like me 3 | 3

4 | 4

Very much like me 5 | 5

1. I find it difficult to depend on other people. **Fearful**
2. It is very important to me to feel independent. **Dismissing**
3. I find it easy to get emotionally close to others. **Secure**
4. I want to merge completely with another person. **Att_1**
5. I worry that I will be hurt if I allows myself to become too close to others. **Fearful**
6. I am comfortable without close emotional relationships. **Preoccupied-R & Dismissing**
7. I am not sure that I can always depend on others to be there when I need them. **Att_2**
8. I want to be completely emotionally intimate with others. **Preoccupied**
9. I worry about being alone. **Secure R- done**
10. I am comfortable depending on other people. **Secure**
11. I often worry that romantic partners don't really love me. **Att_3**
12. I find it difficult to trust others completely. **Fearful**
13. I worry about others getting too close to me. **Att_4**
14. I want emotionally close relationships. **Att_5**

15. I am comfortable having other people depend on me. **Secure**
16. I worry that others don't value me as much as I value them. **Preoccupied**
17. People are never there when you need them. **Att_6**
18. My desire to merge completely sometimes scares people away. **Att_7**
19. It is very important to me to feel self-sufficient. **Dismissing**
20. I am nervous when anyone gets too close to me. **Att_8**
21. I often worry that romantic partners won't want to stay with me. **Att_9**
22. I prefer not to have other people depend on me. **Dismissing**
23. I worry about being abandoned. **Att_10**
24. I am somewhat uncomfortable being close to others. **Fearful**
25. I find that others are reluctant to get as close as I would like. **Preoccupied**
26. I prefer not to depend on others. **Dismissing**
27. I know that others will be there when I need them. **Att_11**
28. I worry about having others not accept me. **Secure R- done**
29. People often want me to be closer than I feel comfortable being. **Att_12**
30. I find it relatively easy to get close to others. **Att_13**

Scores for each attachment pattern are derived by computing the mean of the four or five items representing each attachment prototype.

Secure = Att_Sec_(#1-5) scale is the average of 3, 9 (Reverse), 10, 15, 28 (Reverse)

Fearful = Att_Fea_(#1-4) scale is the average of 1, 5, 12, 24

Preoccupied = Att_Pre_(#1-4) scale is the average of 6 (Reverse), 8, 16, 25

Dismissing = Att_Dis_(#1-5) scale is the average of 2, 6, 19, 22, 26

Unused items = Att_(#1-13) 4, 7, 11, 13, 14, 17, 18, 20, 21, 23, 27, 29, 30

Appendix F

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

Please rate each statement as honestly as you can:

Agree | 3

Partly Agree | 2

Partly Disagree | 1

Disagree | 0

Variable name= Help_(1-10)

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

2 The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. **R**

3 If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

4 There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help. **R**

5 I would want to get psychological help if I were worried or upset for a long period of time.

6 I might want to have psychological counseling in the future.

7 A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

8 Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. **R**

9. A Person should work out his or her own problems; getting psychological counseling would be a last resort. **R**

10. Personal and emotional troubles, like many things, tend to work out by themselves. **R**

Higher scores equal more positive attitudes toward help seeking

Reverse score as (0,1,2,3): **2, 4,8,9,10**

Straight score as (3,2,1,0)

Appendix G

Missing Values

In total, 225 participants responded with 15,075 total possible responses of which 119 responses were missing with a range of 0 to 6 for a given set of questions. The missing values were replaced with the mean score for each question.

Homo Pub 1 = 1 case with a mean of 3.2 = 3

Homo Soc 1 = 3 cases at 2

Homo Soc 2 = 2 cases at 5

Homo Soc 3 = 1 case at 4.4 = 4

Homo Soc 4 = 1 at 3.5 = 4

Homo Soc 5 = 1 at 2.6 = 3

Homo Pub 3 = 2 at 2.3 = 2

Homo Soc 6 = 3 at 3.5 = 4

Homo Soc 4 = 1 at 2.6 = 3

Homo Pub 5 = 1 at 2.4 = 2

Homo Pub 6 = 4 at 3.8 = 4

Homo Stig 1 = 2 at 3.4 = 3

Homo Mor 1 = 2 at 2.6 = 3

Homo Stig 2 = 3 at 5.6 = 6

Homo Mor 2 = 1 at 3.4 = 3

Homo Stig 3 = 1 at 3.8 = 4

Homo Stig 4 = 2 at 2.9 = 3

Homo Pub 7 = 0

Homo Stig 5= 0

Homo Pub 8= 1 at 2.2 = 2

Homo Mor 3= 3 at 1.6 = 2

Homo Pub 9= 3 at 2.8 = 3

Homo Stig 6= 2 at 2.2

Homo Pub 10= 0

Homo Mor 4= 0

Att Fear 1= 1 at 3.2 = 3

Att Dis 1= 2 at 4.2 = 4

Att Sec 1 = 0

Att 1 = 1 at 2.8 = 3

Att Fear 2= 2 at 3.2 = 3

Att Dis 2= 0

Att Pre 1= 1 at 3.5 = 4

Att 2= 3 at 3.2 = 3

Att Pre 2= 1 at 3.4 = 3

Att Sec 2 = 2 at 2.4 = 2

Att Sec 3= 4 at 2.6 =3

Att 3= 3 at 2.8 = 3

Att Fear 3= 1 at 3.4 = 3

Att 4= 3 at 2.7 = 3

Att 5= 4 at 4.2 = 4

Att Sec 4 = 5 at 3.7 = 4

Att Pre 3 = 3 at 3.5 = 4

Att 6= 3 at 2.3 = 2

Att 7 = 2 at 2.0

Att Dis 3 = 4 at 4.1 = 4

Att 8= 2 at 2.6 = 3

Att 9 = 3 at 3.0

Att Dis 4 = 2 at 2.5 = 3

Att 10 = 3 at 2.8 = 3

Att Fear 4 = 2 at 2.4 = 2

Att Pre 4 = 1 at 2.6 = 3

Att Dis 5 = 1 at 3.4 = 3

Att 11= 6 at 3.2 = 3

Att Sec 5 = 4 at 2.9 = 3

Att 12= 1 at 2.5

Att 13 = 1 at 3.0

Help 1= 2 at 1.6 = 2

Help 2= 2 at 2.2 = 2

Help 3= 0

Help 4= 0

Help 5= 1 at 2.2 = 2

Help 6= 4 at 1.9= 2

Help 7= 1 at 1.6 = 2

Help 8 = 2 at 1.7= 2

Help 9 = 1 at 1.9 = 2

Help 10 = 1 at 1.8 = 2